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AIDS AND THE THIRD WORLD: THE IMPACT ON DEVELOPMENT

HEARING

BEFORE THE

SELECT COMMITTEE ON HUNGER
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

SECOND SESSION

HEARING HELD IN WASHINGTON, DC, JUNE 30, 1988

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AIDS AND THE THIRD WORLD: THE IMPACT ON DEVELOPMENT

THURSDAY, JUNE 30, 1988

House of Representatives,
Select Committee on Hunger,
Washington, DC.

The committee met, pursuant to notice, at 10:05 a.m., in room B-318, Rayburn House Office Building, Hon. Mickey Leland [chairman of the committee] presiding.

Members present: Representatives Hall, Panetta, Penny, Flake, Mfume, Gilman, Bereuter, and Upton.

OPENING STATEMENT OF HON. MICKEY LELAND, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Chairman Leland. Good morning. I would like to welcome you to today's hearing on the impact of AIDS in the Third World.

On June the 1st of this year the World Health Organization announced that AIDS cases have been reported in 129 of the world's 170 countries. In those countries there have been 96,000 cases reported, but experts believe the actual figure is over 200,000. Unless scientists find a cure or a vaccine, which most think will not happen for a number of years, these 200,000 people will die.

That is, of course, only the beginning. There are 5 to 10 million more people carrying the AIDS virus, and many experts believe that all of them will develop AIDS itself. Carriers of the virus may show no symptoms for 10 years or more, and they can unknowingly pass the virus on to others. The AIDS virus could easily infect millions more people if its spread is not checked.

The numbers are grim. The reality of the disease is awful. There are, however, steps that we can take now to limit the damage that AIDS will cause. The purpose of today's hearing is to look at what is being done to prevent the spread of AIDS in developing countries, and in particular what is being done to ensure that AIDS does not undo progress—progress in expanding primary health care services or the Child Survival Revolution, for example—that has been made in recent years.

AIDS in the Third World affects not only those who carry the virus. AIDS endangers the overall development of countries, which is our primary concern here today. Immunization, breast-feeding, food production, and economic growth can all be affected by the AIDS epidemic. Setbacks in any of these areas eventually will threaten the lives and well-being of millions who have not been exposed to the virus—literally generations of people. Similarly, the resources required to fight the spread of AIDS are enormous, and if more funding is not provided for specific AIDS programs, existing programs such as population, health, and child survival could be slowly transformed into AIDS programs.

We will be looking closely at these issues today. It is essential that the United States provide adequate funding for international AIDS efforts. It is equally important that the U.S. funding be spent effectively, not only to fight the spread of AIDS but also to strengthen and protect development in the Third World. If we miss this opportunity now, the cost in human and economic terms may be far higher than we can imagine and certainly higher than we can afford. The world is just too small for us to ignore this problem. We must help those in need, wherever they are.

I would like now to turn to my colleagues and ask if they would have opening statements. The gentleman from Michigan, Mr. Upton.

Mr. UPTON. No opening statement, Mr. Chairman.

Chairman LELAND. Mr. Bereuter, the gentleman from Nebraska.

Mr. BEREUTER. No, thank you, Mr. Chairman. I do commend you for holding these hearings, and I look forward to the testimony. Thank you.

Chairman LELAND. I thank the gentleman.

We will now go into the introduction of our witnesses for today. We have some very good witnesses, I might add, and I am very pleased that all of you would respond so positively and so readily.

We are honored to have with us today the Honorable Princess Elizabeth Bagaya, the Ugandan Ambassador to the United States, and the Honorable Wanume Kibedi, who is the Ugandan Ambassador to the United Nations. Uganda has one of the highest incidences of AIDS in the world, but it also has one of the most effective AIDS programs in the world.

Uganda has been in the forefront in the fight to control the spread of AIDS. We note that the leadership of the Ugandan President, Mr. Yoweri Museveni, has been essential to the implementation of AIDS control measures in Uganda. Ambassador Bagaya and Ambassador Kibedi have both shown great interest in the control of the spread of AIDS in the Third World, and we look forward to their testimony today.

Madam Ambassador and Mr. Ambassador, our deepest welcome. We are happy that both of you can be with us today. Please proceed in any order that you may wish to provide your testimony. Madam Ambassador.

STATEMENT OF HON. PRINCESS ELIZABETH BAGAYA, AMBASSADOR TO THE UNITED STATES FROM UGANDA

Ambassador BAGAYA. Thank you very much indeed for your introduction. I am here in a supportive role to the parliamentary representative to the United Nations, because he has followed this subject over a very long time. He has written extensively about it. Although I am the Ambassador accredited to the United States and therefore responsible for Uganda's policies in this area, today I am only here in a supportive role, and of course totally answerable for whatever happens, but I have full confidence in Ambassador Kibedi, and I am here really to learn also from what he has to say.

Thank you very much.

Chairman LELAND. Thank you very much.

Mr. Ambassador.

STATEMENT OF HON. WANUME KIBEDI, AMBASSADOR TO THE UNITED NATIONS FROM UGANDA

Ambassador KIBEDI. Thank you very much, Mr. Chairman. May I start by saying how pleased and in fact honored I am to be here this morning, to appear before this very important committee, and also to exchange with you views on what I consider to be one of the most important problems facing the world today.

I would say that when the problem of AIDS started about the beginning of this decade, one would have been forgiven if one had assumed that this was a passing problem, one that would soon go away. Confidence of course was placed in modern science, that in no time a cure would be found. We are now approaching the end of this decade, and what we face is a pandemic. There is no cure and there is no vaccine, either.

The gravity with which this problem is now perceived in the world can be exemplified by the fact that the matter came up before the United Nations General Assembly last year, which passed a resolution about it. The Assembly commended the work of the World Health Organization in the field of AIDS control and prevention, commended those governments like mine which had set up AIDS control programs, and also urged countries that hadn't done so to do so—that is, set up AIDS control programs.

The resolution also asked the director-general of the World Health Organization to prepare a report about the position of AIDS in the world and to deliver or submit that report to the next Assembly of the United Nations. The director-general has now prepared that report, and it makes somber and instructive reading. I would recommend that the committee does have a look at it, because it sets out the stark facts concerning this matter. The report talks of AIDS as in fact a very, very much increasing problem, and mentions that within this year alone, 1988, there will be more cases of AIDS than in the previous years since the problem started.

So far as the AIDS control program is concerned, we have in Uganda, as you mentioned, Mr. Chairman, one of the most enlightened and forward-looking programs which in fact has been widely commented upon, and has attracted a lot of politicians and serious people to Kampala, Uganda to study how we handle that problem. Right from the beginning, the National Resistance Movement Government which is in power in Uganda decided on a two-pronged policy.

The first one was to keep the people of Uganda informed about the nature of the problem, so that whatever information there was available to the government was, insofar as possible, communicated to the people themselves. Second, it decided on an approach to outside agencies and other governments in an effort to get support in AIDS control measures.

Unfortunately, this policy of openness has been, I would say, exploited by journalistic interests internationally, who have descended on Uganda for the purpose of acquiring or gaining sensational stories, rather than trying to help the people of Uganda in the problems they face.

I would say that the control program that we have is a 5-year one, and it has definite segments. Basically it is a question of trying to inform the public, to educate the general public about these problems.

The importance which the government attaches to this program can be evidenced by the fact that in 1986 the AIDS control program had only two members of staff. Now it has more than 40, three having been seconded by the World Health Organization. Also, in 1986 the program printed about 2,000 leaflets and car stickers for distribution to the general public. In 1988 they have printed over 4 million leaflets and stickers.

Emphasis is placed on going out to the schools and colleges to try and educate the young people about the dangers of the spread of the disease, because surveys have shown that 85 percent of AIDS cases fall within the age group of 20 to 40, whereas the age group of 5 to 14 does not exhibit any signs of AIDS infection. So it is important, taking the fact that there is no infection shown in the age category of 5 to 14, to go out and communicate the message of AIDS control to the young people, because the category of 5 to 14 makes up 50 percent of the population of Uganda.

The government has laid emphasis on that, and the committee which is in charge of the control of AIDS is composed of members from a number of ministries, the churches, the National Resistance Army, institutions of higher learning in Uganda, as well as from the general public. Emphasis is also put on a continual interaction between the control program, the AIDS control program, and nongovernment organizations, in an ongoing exercise of consultation.

Government is particularly concerned about the problem of AIDS not just for the sake of the people immediately concerned—for example, those who are sick and their families—but because the disease has a potential effect on development itself, development of the country. For example, as I said, it affects the category of 20 to 40 by, say, 85 percent, but in fact when you go a little beyond that, the category of 15 to 55 years of age in fact represents about 90 percent of the cases—that is, 90 percent of the AIDS cases that have actually been documented in Uganda are made up of people from 15 to 55 years of age.

Now this is the most productive age category, on which government has expended vast resources in terms of education and other social services. It also provides the bulk of the professions, the police, the Armed Forces, the businessmen, and therefore if the problem is uncontrolled, one can see that there can be a serious effect on the economic activities of the country, so there is that problem of the age category. There is also the fact that in Uganda, as indeed elsewhere in Africa, the problem affects men and women almost equally, unlike in other countries where it affects men because of homosexual activities and possibly intravenous drug abuse. In Uganda, in Africa, it is basically a problem of heterosexual contact, and therefore men and women are affected almost equally.

Uganda is basically an agricultural country, and women do play a very, very important part in that area, in terms of growing crops like cotton and coffee, upon which the bulk of export earnings are based, and even crops for domestic consumption. Women are there in the gardens, tilling the land and making a very, very important contribution to the economic activities of the country. Therefore, if they are affected to a very large extent, one can see that it would have a direct bearing on agricultural production.

There is also another element there, that 10 percent of the AIDS cases which have been documented fall within the category of zero to 1 year; that is, they are babies, up to 1 year old. These would have got the virus from their mothers at the time of birth, either just before or during birth, what is in fact referred to as perinatal transmission.

So you can see that where a woman is infected there is the problem of agriculture, and there is also the problem of transmitting that disease to a child, which as far as the World Health Organization is concerned has the possibility of about 50 percent of the mother transmitting the virus to her baby during birth. So that is another possibility of its effect on development.

The third one, of course, is that because there is no cure and there is no vaccine, the problem does call for enormous resources on the part of government in terms of trying to educate the general public, and also the young people, about this.

Now for most developing countries, resources for development are a scarcity. I cannot overemphasize that. Therefore, if a chunk of those resources is applied toward an unexpected problem like AIDS, you can there again see that there is a limit in terms of what the country can do to cope with its developmental needs.

So those are three areas where the problem of AIDS can have a direct bearing on development.

There have, of course, been arguments in the past as to where AIDS originated, and there have been suggestions which have now been discredited that there was a possibility of green monkeys having transmitted this disease to humans, but I am glad to say that the two scientists who originated this theory have now come out in public and said that the theory was mistaken. But I would say that arguments as to where the problem started or who caused it are really diversionary. We feel that what is important is for resources to be made available for the task of educating the general public, combating the disease, and doing research work in all aspects of the problem. That is what matters. In fact, as someone said, what matters is not where AIDS came from but where it is going.

Last year the ministry of health and the AIDS control program in Uganda did sponsor a conference jointly with WHO, a conference in Uganda which was a donors conference; that is, one intended to raise funds. There was a very good response at the conference, in that many countries and many agencies did come up with valuable contributions and pledges which have now been largely honored, and I am glad to say that the U.S.A. has played an important role in terms of financial contributions to the AIDS control program in Uganda.

But the message and the appeal which I would make to this committee is that the committee should redouble, or should make a recommendation, that whatever financial assistance is being provided to the AIDS control program in Uganda should not be stinted. It should be redoubled, because Uganda went through a long period of time, some 20 years or so, of civil upheavals due to the activities of previous regimes, and much of the infrastructure was destroyed. So now whatever earnings the government can generate on its own part are greatly and desperately needed in other areas of development.

The written statement which I have provided to the committee, and which the chairman I am sure will at some stage look at, does give figures in terms of what the U.S. Government or U.S. agencies have contributed to the AIDS control program in Uganda. Some of that assistance was in the form of pledges. Other forms of assistance have been over and above pledges previously made. Some have been in hard currency. Some assistance was in local currency. I would say that this assistance is greatly valued and it should be redoubled.

That is the message and the appeal which I would like to leave with this committee, and I thank you very much.

[The prepared statement of Ambassador Kibedi appears at the conclusion of the hearing, see p. 48.]

Chairman **Leland**. I want to thank you, Mr. Ambassador and Madam Ambassador, for your contribution not only here this morning but also in the example that you in Uganda have set for other countries in Africa and in the Third World in general.

Let me ask you, your country, your government, has been widely praised for its efforts to combat AIDS, as I have indicated in my opening statement. Uganda has implemented one of the most comprehensive and effective AIDS programs in the world, while many other governments have been reluctant to acknowledge that they have any AIDS problem at all. Why is this so? Is it because of the fear of the prejudices that might be heaped upon those nations? Don't let me lead you. Let me ask you, why is this so? How is Uganda able to face the problem openly and frankly, when so many others do not?

Ambassador **Kibedi**. Yes, I recognize that that has been in fact the attitude of some governments, but the Ugandan Government has taken the opposite line; that is, going out in the open, because of its general enlightened outlook, that if there is a national problem, that has to be aired so that the people in the country can understand what the nature of the problem is.

But I would say that the effect of prejudice also has played a part in this, because what has happened is that some governments have noticed that because of theories, of issues like where AIDS started and what not, some countries have been in the habit of imposing restrictions on certain nationals, for example, travel restrictions. It has also come to light that when some nationals of certain countries do move around, even if for example they are just students going to embark on courses, there is an automatic sort of health check on them. Even if there are areas of doubt, students who are suspected of having this problem are in fact sent back automatically.

Now not much is actually heard in the international media about these practices, but they do happen, so it may well be that governments are concerned about the adverse sort of publicity that followed early reports of AIDS. There has been, of course, talk of considerations of tourism and what not. That is not something that I can comment on or vouchsafe as to its authenticity or accuracy, but I would say that it has been maybe a combination of factors. As time does go on—and as I said, the problem came before the General Assembly only last year—more and more governments are coming out in the open to admit that the problem does exist.

Chairman **LELAND**. To what extent has the OAU involved itself in helping to bring this problem to light in those countries where there is a serious problem?

Ambassador **KIBEDI**. In fact, the part that the OAU has played has been more in terms of cooperating with the United Nations, where the matter came up for debate last year, as I said, and that is where the African group has played an important part in terms of taking part in debates on this issue. But of course in terms of the OAU, which is an organization of some 50 countries, what we have to remember here again is that AIDS really is not a problem that affects each and every country in Africa.

In fact, if you look on the map of Africa you would see that there is a pattern or a trend to it, and that is basically countries within the central part of Africa which have been affected by this. Countries in the north, for example, or in the west or even the southern part of the continent have not been to a great extent affected by this problem. There are isolated cases, and even in those areas where the problem does exist, it is mainly in the urban areas. So I would say that although the OAU has not taken the matter up specifically as an issue, it has through its members contributed to debates in the General Assembly.

Chairman **LELAND**. I understand that U.S. A.I.D. has provided technical assistance to Uganda to help with your AIDS program.

Ambassador **KIBEDI**. Yes.

Chairman **LELAND**. Can you tell us what sort of assistance your country has received from the United States.? How effective has the assistance been?

Ambassador **KIBEDI**. Yes. As I said, I do sort of deal with this in a little more detail in my written statement, but I can say here that the assistance has been in the form of the cost of equipment which has been imported from the United States, for example, equipment for testing of blood. In 1986 there were just one or two centers but now there are 13 centers, and in fact another 16 blood screening centers are due to be opened very shortly, so that within the period of the next few weeks or so there will be a total of 29 blood screening centers in Uganda.

Now there has been a problem in this area in some parts of the country, in areas where there are no electric services, but I am glad to say that equipment which has been ordered from the United States will make it possible to screen blood even in those areas where there is no electricity, because there is special equipment for this.

Some of the assistance has been in local currency, as I said, which has been applied toward the support of the management of the AIDS control program, in terms of payment of staff wages and acquisition and payment for other local services, so it is support which is well recognized.

Chairman LELAND. Very good. Thank you.

The gentleman from Michigan, Mr. Upton.

Mr. UPTON. Yes. Thank you very much for coming this morning on this very important topic. I must say, in reading your testimony, I think you have done a very good job summarizing it in the remarks that you have made. I of course am delighted to see that your country has done everything possible with regard to education in the nearly 7,000 school systems that you have.

I have a couple of questions. No. 1, I note that you indicate that you have printed more than 4 million posters and bumper stickers and that type of thing——

Ambassador KIBEDI. Yes.

Mr. UPTON [continuing]. And I would be very interested in the message that those posters might relate. Do they stress abstinence? Do they stress use of condoms? What type of message are they trying to deliver to the people?

Ambassador KIBEDI. The message is to "Love Carefully;" that is, you have to be rather careful in terms of your sexual activities. It is not a question of a free-for-all, but the sort of brief message there is, "Love Carefully;" that is, use of condoms, for example, is encouraged, and also the question of limitation of sexual partners. That is the sort of message that is put across.

It is really directed toward the sexual activities of the members of the general public because, as I said, really the bulk of the virus is spread through heterosexual contact. So the broad message is "Love Carefully," and what we call in Uganda "zero grazing" is also encouraged; that is, try and limit yourself to one partner. Those members of the committee and members of the general public here who are farmers will understand what the expression "zero grazing" actually means.

Mr. UPTON. I come from an agricultural district, too.

Ambassador KIBEDI. Right, so that is the idea, be responsible and reasonable about this, and try and exercise your sexual appetites reasonably and responsibly. This I would say is a message which could be communicated to members of the general public in any country in the world.

Mr. UPTON. What type of debate has occurred within the government circles, or the general public with regard to those that are actually identified as having AIDS? Is there talk of quarantining them off?

Ambassador KIBEDI. Not at all. There has been no suggestion of measures of any kind, of that kind, quarantine or others, because the makeup of society in Uganda or in most parts of Africa is quite definite about the position of people who are disadvantaged, as through infirmity or through illness. Whatever the nature of the illness, those people are perceived as forming part of the community.

There is no way in which one could try and promote a policy of getting them out of society and putting them in quarantine or anything like that, because it is recognized that they haven't actually committed any crime as such, and that it is a situation where one should feel perhaps pity, not an anger. Therefore one could not advance a case for isolating them, except in the sense of getting them medical attention in a hospital.

Certainly in those instances where AIDS has been confirmed in any particular patient, where the hospitals have felt unable to help a particular patient any further, the patient has gone back into the community and the community has been quite happy and pleased to continue looking after the sick person until his or her last days. So I would say that that argument has not come up at all, and I am sure if it did, it wouldn't proceed far.

Mr. Upton. Well, once again I would commend your country for the educational process that they have undertaken, and I wish you all the luck in the future.

I have no more questions. Thank you, Mr. Chairman.

Chairman Leland. I thank the gentleman from Michigan.

The gentleman from Ohio, Mr. Hall.

Mr. Hall. Thank you, Mr. Chairman.

I have one question for the Ambassador, relative to breast-feeding. We all know the tremendous advantages of breast-feeding in countries all over the world, and yet there is some concern among mothers that breast-feeding could transmit the AIDS virus. As a matter of fact, there have been six cases that we know of in which there appears to have been a transmittal of this virus through breast-feeding. How do we counteract these concerns about breast-feeding when we know the tremendous advantage of it?

Ambassador Kibedi. Yes. This is an issue, of course, which has also come under study by the World Health Organization. As you rightfully said, there have been some, perhaps a few cases where it has been suggested that the virus has been transmitted in that way, but I have to say that even within the World Health Organization there has been no definite statement that that is one of the methods or causes of transmission of the disease. So far as Uganda is concerned, studies that have been made by the AIDS control program have not indicated that as one of the serious methods of transmission.

I would say that, so far as breast-feeding is concerned, this is a natural way of feeding a child in Uganda, maybe in Africa. This is perceived as the natural way of a child growing up. Of course in the past there was a time when powdered milk was greatly encouraged, and feeding bottles were imported in very large numbers, but then studies showed certain adverse effects.

Some of the milk that was imported wasn't really very suitable and was having adverse effects on the children, and mothers were encouraged to go back to breast-feeding, but those encouragements were hardly necessary because for the bulk of the mothers, that was the natural way of bringing up a child anyway. In addition to powdered milk, if that were encouraged as an alternative method, there would in fact be another problem in the sense that you would have to import feeding bottles, and you would have to distribute them across the nation and sell them, get them to be bought by the members of the public. With problems of milk, powdered milk being imported and things like that, there would be an additional burden.

So breast-feeding hasn't been perceived as a problem, and really studies made elsewhere in the world have also indicated the same.

Mr. HALL. So what you are saying, Mr. Ambassador, is that in your primary health programs in Uganda you are continuing to push breast-feeding as opposed to alternative milk. And while you are looking at these few reported cases of transmission through breast-feeding, you are pushing ahead. The fact is that it is more important to breast-feed than to worry about the consequences of six cases.

Ambassador KIBEDI. Indeed, indeed, and as I said, really the bulk of the cases are through heterosexual activity, and also through that period of birth when a mother, through blood, may transmit the virus to the baby.

Mr. HALL. Let me ask one other question relative to immunization. This committee has very strongly advocated the immunization of children in the world. As a matter of fact, in our child survival programs, one of the primary emphases is immunization.

In the immunization programs in Uganda, how are concerns about AIDS integrated into the immunization efforts?

Ambassador KIBEDI. Yes. In that area I am glad to say that UNICEF is very, very active—not only UNICEF but other child care agencies like the Save the Children Fund, which is based in London—but UNICEF has a program of immunization which is conducted jointly with the Ministry of Health, and the program has been an ongoing one for a number of years. Of course, there are a number of diseases endemic in the country but which can be controlled by immunization programs, so that has been going on for many years in Uganda and on a national basis.

Of course, at the moment an immunization vaccine is not in existence so far as the problem of AIDS is concerned, and it is the traditional diseases that can be controlled through immunization programs that are dealt with. As I said, there is a UNICEF program on this and it has been going on for many years.

Mr. HALL. Are there programs going on in Uganda to reteach sterilization and to promote the use of disposable needles, because of the tremendous incidence of transmittal of this AIDS virus? Has that been stepped up in your country because of this?

Ambassador KIBEDI. Yes, yes. It is in fact one of the elements of the program, the AIDS control program; that is, provision of fresh needles for medical use. It is now of course recognized that this is one of the hazards or the areas where the virus can be transmitted, and therefore the doctors and medical personnel in general have had it stressed that needles have to be changed all the time, whenever they have been made use of, either that or sterilized, so this is another message. In terms of injections, because of the shortage of doctors there is a range of personnel who can actually undertake this sort of job; that is, injecting people, so it has been emphasized that needles, if they are made of steel, have to be sterilized before they are used again, and so far as possible they should be disposed of; that is, for those which are disposable.

Mr. HALL. Thank you.

Thank you, Mr. Chairman.

Chairman **Leland**. I thank the gentleman from Ohio.

The gentleman from Nebraska, Mr. Bereuter.

Mr. **Bereuter**. I thank the Ambassadors for their testimony and for their willingness to be here.

Ambassador Kibedi, you mentioned that at this point there seems to be virtually no infection among the age category 5 to 14, which constitutes 50 percent of your population.

Ambassador **Kibedi**. Yes.

Mr. **Bereuter**. I am wondering—well, first of all, it would appear that there would be a reduced amount of exposure, but you have the educational programs that may be having an impact, hopefully, on them. Is there any indication that this generation is more likely to be free of AIDS? Is there any indication that there is some kind of community that in fact would be developing a tolerance to the AIDS epidemic?

Ambassador **Kibedi**. No, no indications at all that there is a possibility of immunity or tolerance, but it really sort of comes up that way because of how long the virus has been around, because in Uganda it came to light about 4 or 5 years ago. That period was when it started, and the first case was in about 1982 or 1983, that period.

Although there is no immunity as such, studies have shown that this age category is largely free of the virus. The government, recognizing this, has made every effort to try and convey the message to this category in respect of their sexual habits, and that is where the school health programs have been extremely important. At the moment at least 2,000 teachers have been trained in these sort of health programs; that is, to be able to communicate to the children what sort of measures they should take to take care of themselves. That is because it is hoped that once this age group gets the message, then they can continue that way throughout life; that is, with the proper sort of conduct in terms of their sexual activities, thereby ensuring the good of the country as a whole.

Mr. **Bereuter**. Ambassador, fabricated documents were being used in Africa which indicated that the American Government and the American people were encouraging the spread of AIDS in Africa to devastate the continent, and we have traced back those documents to the Soviet Union. That disinformation was the subject of President Reagan's conversation with the General Secretary, General Secretary Gorbachev, and he asked him to desist from that practice. It may well have stopped, but perhaps it affects the credibility of our efforts to assist. Democracies in Western Europe were also implicated by those false documents, but primarily the United States.

To what extent did this disinformation have widespread impact, if at all, in Africa? In other words, to what extent do our efforts to assist you and other African nations run into a credibility problem? Are our programs and efforts going to be trusted, or did this Soviet disinformation have its impact?

Ambassador **Kibedi**. No, it hasn't. If there has in fact been a campaign on the part of the Soviet Union, or in fact on the part of any country, it has not had any impact at all in Uganda. We have, of course, heard of such rumors and in fact other rumors in terms of the sources of this virus, but this is a matter which really the

Government of Uganda has not placed any concern about, because the government recognizes that the task is to recognize that this problem is there and that it has to be dealt with. The sort of story that you mentioned here has actually featured in some newspapers, but as far as I know these stories have not been credible and nobody has really taken them seriously. Personally I have not seen any of the documents which set out that proposition——

Mr. **Bereuter**. I have, unfortunately.

Ambassador **Kibedi**. Sir?

Mr. **Bereuter**. I have, unfortunately.

Ambassador **Kibedi**. You have, unfortunately, yes. Well, I haven't, and I don't think I have missed much.

Mr. **Bereuter**. No, you haven't.

Ambassador **Kibedi**. No.

Mr. **Bereuter**. I am glad to hear your reassurance. I noticed in your testimony that it wasn't until the recent, the 42nd General Assembly, that the subject of AIDS and its control and prevention came up before the United Nations.

Ambassador **Kibedi**. Yes.

Mr. **Bereuter**. I happen to have been a delegate to that 42nd General Assembly as well. I am wondering why it is that we have had this lack of expeditious action or concern on the part of the United Nations?

Ambassador **Kibedi**. Well, I suppose one could say that maybe on the part of the United Nations, but maybe on the part of the countries of the world—because, after all, the United Nations is just a conglomeration or a composition of the nations of the world—and action at the U.N. has to be generated or sponsored by some country, somewhere in the world, and that is how this matter came up. The debate came up because initially it was before the World Health Assembly, which also passed a resolution about it.

I think the fact that it did come up last year just indicates the seriousness with which the problem is now perceived, because it is a problem that has been with us for maybe 6 or 7 years. In the early days the perception was, "Oh, it's a problem that affects certain categories of people. It's a problem that affects maybe other countries, other regions, and not us." But I think as time goes on it is being recognized that it does concern all, and in fact is a problem for the world as a whole.

I agree with your assessment there, that it is a pity that it did not come up earlier on, maybe, but the fact that it has actually come up in the end is a positive thing because it is better late than never.

Mr. **Bereuter**. It is a disappointment, and I think it is a tragedy, really, that it wasn't focused upon earlier. This is the logical place for it to be focused on, this worldwide problem, the United Nations. In any case, I hope that we will have expeditious action.

Ambassador **Kibedi**. I hope so, too, but may I say on that point that there is also a comparable problem, that even on a national basis, some individual countries have had this problem which we are talking of. For example, there are many countries that haven't been able to set up national AIDS control programs because they feel maybe the problem is not urgent enough, so not only the U.N.

but individual countries I think have something to answer as far as this problem is concerned.

Mr. **Bereuter**. Finally, very briefly—I think you can answer this quickly—picking up on what Congressman Hall asked you about the transmittal through needles and lack of sanitation, are these disposable needles in widespread use outside the medical profession? Is that a significant problem that we would have to deal with in Uganda or elsewhere, of unauthorized people using them, for example?

Ambassador **Kibedi**. Yes. Disposable needles for medical use you have in mind. Is that right? Yes, I would say they are in widespread use, especially in terms of the recent progress of the fight against AIDS, but traditionally hospitals and dispensaries and health centers have used steel needles which have had to be sterilized, in spirit or boiled in hot water before they can be reused. But now with the impetus of the fight against AIDS, disposable needles are coming more and more into use.

Mr. **Bereuter**. Thank you, Mr. Chairman.

Chairman **Leland**. The gentleman from California, Mr. Panetta.

Mr. **Panetta**. Thank you, Mr. Chairman.

Let me ask, in your testimony you state that the number of cases, the AIDS cases in Uganda, is doubling every 6 months. Is that correct?

Ambassador **Kibedi**. Well, that is the information I got last week from the director of the AIDS control program.

Mr. **Panetta**. I guess the concern I have, in your testimony you mention the fact that obviously Uganda is dealing with problems resulting from social upheavals of the recent past——

Ambassador **Kibedi**. Yes.

Mr. **Panetta** [continuing]. And that you are dealing with problems of endemic diseases—tuberculosis, tetanus, malaria, and diarrhea—health problems related to malnutrition and anemia, which I am sure are probably far greater killers than AIDS at this point in Uganda.

Ambassador **Kibedi**. Right, right, yes.

Mr. **Panetta**. A question I would ask you—because what I see here is kind of a deathly "Catch 22" situation, in which as you try to devote resources to the AIDS problems, you are taking resources away from other problems that you are facing in the country—my question is, is that the prospect that you are facing?

Ambassador **Kibedi**. Well, that would in fact appear to be so, and that is why I have made the appeal that I have done, both orally before the committee here and also in my written statement. It is a problem which is very real, and I believe that it can only be tackled by provision of greater resources that would enable the government to deal with the problem which you have so ably outlined.

Mr. **Panetta**. How much are you spending right now in the AIDS area? Do you know the cost number?

Ambassador **Kibedi**. I'm sorry. In the——

Mr. **Panetta**. Dealing with AIDS, how much are you spending right now on that program?

Ambassador **Kibedi**. Right. Well, the program, the immediate program, which is a medium-term plan which goes on until the end of this year, is $4.5 million. That is its budget.

Mr. PANETTA. That represents about 10 percent of your overall budget in Uganda?

Ambassador KIBEDI. Well, that is the budget of the plan itself, but in terms of the expenditure on the AIDS problem, obviously the expenditure will go beyond that because, apart from the program itself, there are other governmental activities of the Ministry of Health which are also designed to deal with the AIDS problem. So I would not say that $4.5 million actually represents 10 percent of the budget of the Ministry of Health.

Mr. PANETTA. Let me ask you this: If you are looking at a doubling of the AIDS cases every 6 months right now——

Ambassador KIBEDI. Yes.

Mr. PANETTA [continuing]. Is there any point, I mean, when your officials tell you when that may slow down? Is there any prediction on that, or are we looking at that doubling situation over a period of time?

Ambassador KIBEDI. There is no indication as to when that sort of period might start, but I would say that already there are indications of progress, of benefits from the program which the Ministry of Health has launched. For example, indications are that even the usual sexually transmitted diseases have actually fallen, gauged by the number of patients that attend venereal disease clinics, either private or at government hospitals.

In other words, the message is getting across; that is, "Love Carefully." So though the immediate indications are that cases are doubling every 6 months, there is great hope and expectation in fact that with this could be taken care of, that you can actually try and stem the advance of the problem, because by and large most people do recognize the dangers that this poses for the country and they are trying to be careful now.

Mr. PANETTA. Thank you. We have a vote on the floor of the House, but let me just state that I commend you and the Government of Uganda for the work that you are doing in this area. Obviously it is a very tough challenge for the whole world, and the steps that you are taking are at least an effort to try to deal with what is clearly a serious epidemic in the world.

Thank you.

Ambassador KIBEDI. Thank you very much.

Chairman LELAND. I thank the gentleman from California.

If the Ambassadors can stay with us just a little while longer, I am going to ask that you stand by. We are going to take a brief recess to go to the floor to vote and come right back. Thank you.

[Recess taken.]

Chairman LELAND. We will now reconvene, and now I will call on the gentleman from Maryland, Mr. Mfume.

Mr. MFUME. Well, thank you very much, Mr. Chairman, for allowing me to catch my breath. [Laughter.]

Mr. and Madam Ambassador, let me thank both of you for being here today and for offering your testimony. I read with great interest your formal remarks, and I was fascinated by the extent of a program that you have underway in Uganda to bring under control this dreaded disease.

I would like to follow up on a point raised by my colleague from California, as it relates to the amount of national resources that you are currently targeting toward your efforts. It is significantly high, but I think justifiably so. I am concerned, if you could give me an idea, and perhaps other members of the committee, to what extent that is affecting your ability to deal with other health-related matters, because it is such an enormously high percentage of your budget, and how long you think you may be able to sustain that level of funding.

Ambassador KIBEDI. Yes, I would say you are quite correct. It is a high percentage of the budget, and it is one which we can hardly afford, but here I would say that the assistance and the contributions made by outside agencies have been crucial. For example, the World Health Organization and UNICEF and countries like Sweden, the U.S.A., the United Kingdom, and others that have actually made contributions, they have made contributions maybe in terms of cash or medical supplies or equipment, so that has been of great help. But certainly if the problem were left to Uganda alone, it would be a very, very difficult problem to cope with.

Mr. MFUME. Has your nation, by the simple eloquence of your example in this area, been able to serve to foster that same sort of a commitment or desire on behalf of some of your neighbors who are also beset by the problem, and who perhaps are looking to Uganda—certainly as many of us in this nation are—with a great deal of pride in the way you have gone at this, perhaps probably more so, I think, than any other Third World nation in terms of admitting, as you indicated in your testimony, that first we have to admit to ourselves that there is a problem before we can adequately go after it. You have done that. You have a very aggressive effort. I was wondering to what extent neighbors in the region have come to you for advice or have come to you to sort of pattern a model for their own country's efforts in this regard?

Ambassador KIBEDI. Yes, you are quite correct. There has been a response of that nature, not only from our neighbors but in fact from many other countries in the world. In fact, only about 2 or 3 weeks ago we had a request from the government of an island which is very, very far away from Uganda—it must be thousands of miles—and the request was for a delegation from their Ministry of Health, led by the Minister himself. The request was that they would want to visit Uganda to study our program, and of course we were very pleased and quite happy to receive the delegation and assist them in every way possible. So the response, in terms of other countries following our example, has been there.

I would also mention that we had—as I mentioned in my written statement—the conference, the donors conference in May 1987, which was attended by locally based agencies and Ambassadors. Now the response there was so positive that the example of a donors conference has been followed by 11 other African countries since then, and some of those countries have been within our region. Our neighbors have followed that, but Uganda certainly was the first country to approach international agencies and to organize an open conference, a donors conference, to generate funds for its program. That, as I said, has been followed by 11 other countries, and we have been pleased that in a small way we have made a contribution to the measures that can be taken against this problem.

Mr. **Mfume**. Now you indicate on page 11 of your testimony that currently there are 13 blood screening centers that are operational in the country, and that another 16 are projected to be operational within the next 2 months.

Ambassador **Kibedi**. Correct.

Mr. **Mfume**. This may be a difficult question but I would like for you to take a stab at it, if you would, Mr. Ambassador. In terms of the overall blood supply, given the resources that you have in place now with these centers and what you anticipate coming on line in 2 months, would you say that perhaps 50 percent of the Nation's blood supply is free of AIDS contamination, or 40 percent or 60 percent? Do you have any idea at all as to what sort of impact, as a result of your efforts in this area, you have been able to make in at least removing contamination from a large part of the blood which is used ultimately for transfusions?

Ambassador **Kibedi**. That is difficult for me to sort of put down in percentages, but I would say that broadly the availability of this equipment has actually enhanced the safety of the blood that is used in transfusions for patients. It has been positive. Of course, there is no doubt that some contaminated blood has actually been picked up through these tests. But on the question of blood donations, there have been stories of percentages of infection in donated blood, but I would say that the approach is different in Uganda.

In many countries maybe you would go out in the streets and ask for blood donors and what not, whereas in Uganda the approach would be that where, for example, a mother were in an accident or a woman and blood was needed, the medical authorities would first go to the husband and ask for a donation. Now if the wife is infected and you ask for blood from the husband, the chances are that the husband would be infected as well, and that is why there have been these instances of, say, out of donated blood there is a certain percentage which is contaminated, and that percentage appears to be very high.

It may be high but there is a reason for that, and that is that when you ask for donations, you are really asking within the circle of the family of the patient. You are not just going out to strangers, as appears to happen in many countries in the world. I thought I should mention that, but specifically on your point, it is difficult to put a percentage, but overall the effect of this equipment has been positive.

Mr. **Mfume**. Just for the record, I would like to indicate that I think it is personally regrettable that a nation such as yours, that would seek to deal in a rather forthright manner with this disease, as you have to——

Ambassador **Kibedi**. Yes.

Mr. **Mfume** [continuing]. That you would come under the sort of criticisms through the press and receive hordes of reporters flocking there looking for a story, and some perhaps looking for sensational aspects of a story, others coming there in a genuine mood to report, but this outpouring of attention with, I don't think, a balancing on the other side by talking about the aggressive efforts that are underway. This is why I read with interest the remarks of Mr. Hilts from the Washington Post Journal of Medicine and Health in which he talked about the other side of the coin, and the fact that by doing this you probably are more advanced than most nations in dealing with the disease itself.

Mr. Ambassador, tell me, what do you think and what are your health experts in the nation, your scientists and researchers, telling you as it relates to the rate of infection and what they project, given the same amount of resources and energy that your nation is putting into this disease and its removal? When do they anticipate a leveling off of the rate of infection? My colleague, the gentleman from California, had mentioned earlier your testimony about it doubling, and you said that could in fact be a bit misleading because of some of the measures that are underway. Have they made or given you projections as to when you might be, as representatives of the Ugandan Government, able to see a leveling off of the infection rate?

Ambassador **Kibedi**. No. That is a question that I haven't taken up with our people in the AIDS control program, so I can't say that they can put their finger on a year where there might be a leveling off or anything like that, because at the moment the emphasis really has been on combating the disease, taking these measures, such as educating the public, which can actually try and generate the sort of leveling off that you have mentioned. We haven't applied our minds, maybe, to a study of when the leveling off may start. Maybe our people in that part of the AIDS control program might have an idea, but that I must confess is an issue that I have not specifically taken up with our people in Uganda.

Now on the question that you have just mentioned, of the sensationalism, it is quite correct, that is one that we have looked at with regret because we felt that we should come out in the open and tell people, in fact the world, about this problem. We did not see any advantage in behaving like an ostrich which put its head in the sand and then pretended that there was no storm which was coming. We felt that in our national interest we should be quite open and forthright about that. Because we said yes, we have this problem, some journalists—not by any means all of them, but some—said, "Oh, yes, they have that problem. Let's go there."

Then they sort of descended, and when they came, naturally they would go and talk to people and patients and what not. These poor patients would be given the impression that here is someone who is actually coming from outside Uganda, thousands of miles away; maybe he is coming with that all-important lifesaving drug or something like that. So there was cooperation because these people felt, well, somebody is coming from outside, surely he must be a good person and he must be bringing some sort of good tidings. So they really opened themselves up in terms of their case histories. They let some of these people in their houses and what not.

What we have seen is that there were ulterior motives, really. The main thing was to get a sensational story which one could then sort of flash across the world, and what we imagine is that some of the journalists had to justify their expenses on trips to East Africa or to Uganda, so they had to come up with something.

But I have no hesitation whatsoever in saying that some of the stories that we have read in some of the publications in the world, or some of the programs that have appeared in many countries, including the U.S.A., have disappointed us because we felt that they have been very one-sided, and they have not in fact tried to balance things out in terms of talking to our people in the AIDS control program to get to the facts. The main thing has been to descend on Rakai, get the man who is actually dying of AIDS, and fly back to wherever, and that I think has been unfortunate.

Mr. **Mfume**. Well, let me thank you, and for what it's worth I will go out on a limb and assure you that all the Washington journalists who are at least in this committee room are the fair and even-handed ones who are going to report your remarks adequately and properly. [Laughter.]

Thank you very much. My time has expired.

Ambassador **Kibedi**. Thank you.

Chairman **Leland**. Well, I certainly hope they write you up, Mr. Mfume, in a favorable way. [Laughter.]

Mr. Ambassador, let me just ask you a hard question that deals with the sociology of all of these problems. I was in Zaire, recently, and I understood that Zaire is not doing very much in its efforts to combat the spread of the AIDS virus. One of the most substantial problems they have is that there is a growing amount of prostitution in Zaire, and the transmission of AIDS is being directly associated with the prostitution. The prostitutes themselves have not been checked, and certainly there is a great degree of unhealthy sex taking place because of that.

To what extent is prostitution serving as a means of transmission of AIDS? To what extent is prostitution causing AIDS to spread in Uganda?

Ambassador **Kibedi**. I would say that prostitution is really a problem of the urban areas.

Chairman **Leland**. By the way, I could say the same thing about the United States. The transmission of the AIDS virus by prostitution is a real problem, especially with the high incidence of I.V. drug use by prostitutes.

Ambassador **Kibedi**. Yes, so I take note of that, and as I said, I was just saying that prostitution is a problem of the urban areas. As far as Uganda is concerned, 90 percent of the population is rural. They live in the countryside, so prostitution is something they just hear of, because traditionally there would be no possibility of prostitution coming up in the villages. Nobody would permit that, because there are regulations, customary modes of behavior, where a young boy or a young girl is expected to behave in a certain way until a certain age. The possibility of such a young lady trying to sell themselves in the villages just does not arise, so it is a problem of the urban areas, but luckily for us, the urban areas are not all that many. You may not have been to Uganda, I do not know. If not, I hope you will go there one day.

Chairman **Leland**. I haven't, and I must admit that I have been a victim of all of the bad propaganda over the years, primarily because of your former president, Mr. Amin

Ambassador **Kibedi**. Yes.

Chairman **Leland**. But I have a greater responsibility these days, and would like very much to go, especially subsequent to the compelling testimony that I have heard you give and the invitation that I have received from the Ambassador Bagaya on more than one occasion.

Ambassador **Kibedi**. Yes. We certainly will be very pleased to see you, and I am sure you will be able to gauge for yourselves how divorced from reality some of the stories are. You will see how vibrant life is in Uganda.

But on this question of urban areas, I was just going to say that really the urban centers are not all that many. You have Kampala, which is the capital, and that is the largest gathering of people, conglomeration of people, in Uganda. That is about half a million people, so by world standards that is not a very large city, really.

You may have instances there, and you get prostitution in these urban areas because that is where the population is sort of cosmopolitan. People are moving in and moving out all the time.

Chairman **Leland**. And it is a center of tourism.

Ambassador **Kibedi**. Right, that sort of thing, so a girl may feel that she can indulge in these activities and get away with it, what would not happen in rural areas. So specifically on your question, I would say that studies done in Uganda do give an indication of this problem among prostitutes, but prostitution as such is not a major problem in Uganda because we would in fact be talking about two or three urban centers, Kampala and maybe some of the towns on the border areas, but the upcountry areas or the countryside villages would not gauge that as a problem.

Chairman **Leland**. Very good. Well, I want to thank you. I don't know if—the gentleman from California.

Mr. **Panetta**. Yes, if I could just ask one additional question.

If we were to go to Uganda and go to a rural area, and walk up to just a person at random, would they know what AIDS is about? What are the chances that they would know about AIDS?

Ambassador **Kibedi**. I would say that now they would. They would, because they would have received the message from government about AIDS. The message would have been carried through the radio. Maybe they would not have a TV set, so we can leave that aside, but possibly they would have access to a radio. Even if they didn't, we have volunteers, something like 200,000 volunteers who have gone out in the countryside to try and tell people about this problem, so I would say that the chances are that the person that you first met on your visit to the countryside would have an idea of this problem.

Mr. **Panetta**. So the education process you think has reached most of the rural community, as well as the urban community?

Ambassador **Kibedi**. Yes, certainly I would say so, and that is where we hope that other countries can be convinced to come in and give us a shot in the arm financially, in terms of support.

Mr. **Panetta**. Well, thank you.

Thank you, Mr. Chairman.

Chairman **Leland**. Let me ask you one last question, Mr. Ambassador. I just introduced a piece of legislation in the Congress that would create an international health corps, which would enable us to send out health professionals and paramedical personnel to different parts of the world. This health corps would assist, complement, and supplement campaigns against not only AIDS but the other problems that we talked about that are afflicting and killing people in Uganda, as well as in other parts of the Third World.

Would Uganda receive such kinds of support to augment the efforts that you are making there?

Ambassador KIBEDI. I believe so.

Chairman LELAND. From this country?

Ambassador KIBEDI. Yes, I really do believe so, because we know that we need the support of other countries, and therefore any measures that are genuine and well-intentioned and look as if they will be effective in terms of the problem or problems that we are facing would, I am sure, be welcome.

Chairman LELAND. Very good. I want to thank both of you very much for coming this morning. You have been very eloquent on the issues, and we again applaud you for the exemplary way that you are working to try to alleviate this problem that is not only afflicting your country but the whole world.

Again, let me just reiterate that the world is small, very, very small, and we are integrally tied to each other. We must work in cooperation with each other to try to resolve pandemic problems of this magnitude. If we don't, then not only Uganda but the United States and everywhere else will literally lose generations of people. I am particularly concerned because young people more and more are coming down with this incredible disease, and it is a very sad commentary on our world. Thank you so much for serving as the example that you are. Thank you so much.

Ambassador KIBEDI. Thank you.

Chairman LELAND. We will next hear from Dr. James Chin, chief of the surveillance, forecasting, and impact assessment unit of the World Health Organization's Global Program on AIDS. WHO has taken the lead in coordinating the worldwide effort to combat AIDS. Currently WHO is working with over 150 countries to develop and strengthen national AIDS programs. Dr. Chin is here today from Geneva to elaborate on WHO's global program, and to discuss in particular the impact that AIDS is having on development.

Dr. Chin, welcome. Thank you for traveling so far to be with us today. We hope that we have not imposed on your time too much by the length of the discussion with the Ambassadors from Uganda, but we thought that their testimony was invaluable. Thank you so much for coming. You may proceed as you wish.

STATEMENT OF JAMES CHIN, M.D., CHIEF, SURVEILLANCE, FORECASTING, AND IMPACT ASSESSMENT, GLOBAL PROGRAM ON AIDS, WORLD HEALTH ORGANIZATION

Dr. CHIN. Thank you, Mr. Chairman, members of the committee, ladies and gentlemen. It is a distinct pleasure to be back in the U.S.A., even if it is only for today. It's nice to be back in an area where a dollar buys a dollar's worth, and where I don't have to spend $2 for an English language newspaper.

I will present my statement and then respond to a couple of the questions that relate to some of the WHO activities.

AIDS is a new human disease problem. The etiologic agent of AIDS, HIV, began to spread extensively and silently among diverse populations in separate geographic areas during the mid- to late-1970's.

At the present time, AIDS is a major public health problem in many countries in sub-Saharan Africa. In some cities in central and eastern Africa, from 10 to 20 percent of the sexually active age groups are infected by HIV. From one-fourth to one-half of all patients hospitalized for medical conditions in these same cities are currently infected by HIV. In these cities, the high infection rate of women in the childbearing ages is expected to increase child mortality by up to 50 percent, thus more than cancelling out all of the gains projected for child survival programs. Total adult mortalities in these urban areas will, because of AIDS, double or triple by the early 1990's.

Health care systems in these developing countries have severe difficulty coping with the current patient load, yet it is predicted by the early 1990's that there may be a cumulative total of about half a million AIDS cases in sub-Saharan Africa. Thus, the impact of AIDS on social and economic development in these areas will be immense, especially since there will be a selective toll of disease and death among the most productive adult age groups.

The World Health Organization has the responsibility to direct and to coordinate international health work. Its Global Program on AIDS—GPA—has worked extensively during the past year to promote support to national AIDS control programs. We are now working with over 150 countries around the world to help strengthen their national AIDS programs. This work involves all countries on the African continent.

As of June 1988, 49 countries on the African continent have had a technical visit from WHO during which a status and needs assessment was carried out, leading to the formulation of a short-term plan of action. This plan aimed at the provision of immediate support to start the work of AIDS prevention and control without delay. On average, about a quarter of a million dollars was provided to these countries for their short-term plan of action.

Now these plans call for activities in the field of information, education, and communication, addressing the public at large as well as specific target groups of persons. These plans also included the strengthening of blood transfusion facilities to help ensure that blood for transfusions can be made as safe as modern technology will allow. It is anticipated by the end of 1988 such screening facilities for blood transfusions will be available in all African capital cities.

During the execution of short-term program, planning activities aimed at the formulation of planning missions were carried out in 28 countries, leading to medium-term plans or MTP's which covered periods of 3 to 5 years. Nine of these plans have thus far been endorsed by the government and the international community at meetings convened by WHO. Eight more of these donor meetings are planned before the end of this year. An exceptionally high level of commitment for the development and support of aggressive national AIDS programs has been seen among ministries of health and the international assistance community.

Now support for the WHO's Global Program on AIDS has been marshalled primarily from extra resources, which we call extra-budgetary funds. Fifteen countries, including the United States, have contributed funds to GPA since 1986. The cumulative amount of funds received to date is slightly over $75 million. GPA expended approximately $22 million in 1986–87, with almost half of this amount directed to support African national AIDS program development. The expected financial need for GPA's work in 1988 will be over $66 million, and over $90 million will be needed in 1989.

Now in addition to these extrabudgetary funds, WHO has provided considerable administrative support and facilities for the GPA. This has placed a severe strain on WHO because this has come at a time when it is facing a severe budget deficit as a result of the nonpayment or delayed payment of assessed contributions by some member countries—not to mention them. [Laughter.]

The GPA will require the continued strong support of external funding agencies. In addition, the global control in the prevention of AIDS will require that national health care systems and other development programs continue to be fully supported and in many situations supplemented.

I would like to comment on the fact that, worldwide, AIDS is primarily an urban phenomenon, and if we look in the developing world, and specifically in sub-Saharan Africa, this is still the case. Our major concern is whether or not there will be significant extension of the focus of infection of HIV from the urban areas into the rural areas. The bulk of the population in the developing world is rural, and so far at the present time, even though we have a major problem, it is a problem that we think is beginning to be well-defined, so our major concern is whether or not there will be any extensive spread.

Because it is primarily urban, its impact on, say agricultural systems, at this time I think is premature to predict. If it does get into the rural population, then I think it will be a major concern. We are also concerned about population migration that might disrupt some of the agricultural systems.

Let me comment on a couple of the questions that have been raised. One was on breast-feeding. One of the major contributions that the World Health Organization can make is to bring together world experts to bear on a specific issue, and I think breast-feeding was one of the concerns. I think there has been ample documentation that it can be spread by breast-feeding. I think those six cases that have been cited are fairly more than suggestive evidence that it can occur.

Now the expert committee, though, that was brought to bear on this issue, their basic conclusion was that the vast majority of transmission from mother to infant is at the time of pregnancy or shortly before or during labor; that whatever infections might, in say the developing world, be transmitted by breast milk would just be a small incremental risk for those infants. Because of the concern of withholding breast-feeding in those situations, which would be more harmful, the recommendation made by this expert group was that breast-feeding not be withheld in developing world where there is concern about HIV spread, even though there may be more than a theoretical concern about that.

Now with regard to immunization, I think that the expanded program on immunization of the World Health Organization has been for years stressing the need for sterilization, and I think that the AIDS problem has brought this problem then more to the surface. I think UNICEF is a major contributor to the expanded program on immunization, and I think their educational programs to assist the World Health Organization in immunization programs are very much appreciated, but the recommendation and the concern I think is being pursued by the expanded program on immunization.

I would like to stress that the amount of HIV infections that we believe might be transmitted by needles is relatively low compared to, say, sexual transmission. We believe that aggressive action should nevertheless be taken. Even though the numbers of infections by needles might be small. they are completely preventable and they should not be tolerated.

With that, I would then just be open for questions at this time. Thank you.

Chairman LELAND. Dr. Chin, thank you very, very much. Again, thank you for the extraordinary lengths that you took to be here with us.

WHO's global program on AIDS has taken on the enormous task of coordinating the efforts of donors who are providing assistance to countries affected by AIDS. What recommendations do you have for donor nations like the United States as we expand our international AIDS efforts? How can the United States contribute most effectively to the global and national AIDS programs?

Dr. CHIN. I will give you the example that we had with Uganda, because Uganda was one of the first countries that was prepared to begin their national AIDS program. At the time that they began planning for their national AIDS program, to gather support, I would say literally there were dozens and scores of external agencies interested in assisting. The kind of problem we had at WHO was that this was not coordinated.

What WHO did, as I indicated in my statement, was to convene a meeting where, after working with the Ugandan Ministry of Health to develop a national AIDS plan, that plan was then presented to external donors at this meeting, I believe it was in March of this year, and full support for their first year of that program was obtained during that meeting. So I think that there has been this international coordination, and I think would we would recommend that this type of coordination continue, because the problem would be, if each agency went off on their own, you would have different evaluations, you would have different pieces of the program being supported and other pieces not being supported.

Chairman LELAND. Many Third World countries, like Uganda, are heavily burdened with debt. They have real financial problems that exacerbate their domestic concerns. Can you just comment on how that makes your job even harder?

Dr. CHIN. It is difficult for me to answer that. My whole public health career has been in sort of infectious disease control, and I look upon the AIDS situation as a new problem. Within WHO it is being addressed by extrabudgetary funding at the present time. In Uganda and in many developing countries, the bulk of their AIDS control support is right now coming from extrabudgetary resources, so I think it is a new problem and it needs a new commitment of additional funding, rather than trying to redirect support from other areas.

Chairman LELAND. I guess I was trying to explore the correlation between the serious debt problems of many Third World nations, and their ability to solve their domestic problems, particularly epidemics or pandemics such as AIDS. In light of this concern, it seems to me that the United States ought to step forward and take a real leadership role in trying to resolve this debt problem.

I know that we are involved to some great extent in attempting to improve the debt crisis, especially through the international banking institutions. But I think that when you have a country like Uganda, that is spending 10 percent of its GNP on a problem like AIDS, they need some additional support, especially in trying to alleviate the very frustrating problem of debt.

If the U.S. Government were to restrict its annual contribution to WHO's global program on AIDS to the $15 to $20 million level, as it currently is doing, what would be the impact on the global program?

Dr. CHIN. It's difficult to say because we have been seeing an outpouring of commitment from many other countries. I think I indicated that we have received support up to now from 15 countries and a couple of other agencies. We believe that the funding would likely be maintained, because I think that there has been given a tremendous international commitment to the control of AIDS. I think it would be regrettable if the United States, with its abundance, did not pay its fair share.

Chairman LELAND. Can you describe for us the steps that WHO would take in helping developing nations to establish a national AIDS program in their country?

Dr. CHIN. Well, as I outlined in my statement, the first would be a request from the government for assistance, and that generally will precipitate a technical visit within several weeks of that request for an initial assessment to see the scope of their problem, what data they have, what their immediate needs are, and what resources could be sort of readily used.

This would result in what we call the short-term plan, which generally is anywhere from 6 months to 1 year, where within several months we are able to get resources and personnel directly into that country for those immediate needs. During that 6- to 12-month period, there is this planning process for the medium-term plan, a more comprehensive look at how the whole problem will be addressed. Then that sets the stage for what we call either the donors meeting or the interested parties meeting, where the national plan which has been approved by WHO and by the member country is then sort of reviewed and commitments are made for support.

Chairman LELAND. Thank you, Dr. Chin.

The gentleman from Nebraska, Mr. Bereuter.

Mr. BEREUTER. Thank you, Mr. Chairman.

Dr. Chin, thank you very much for your testimony. Including the GPA, what percentage of the WHO budget actually spent on disease control or prevention would you estimate is now being spent on AIDS?

Dr. CHIN. On AIDS? I am not that familiar with WHO's budget, so you will have to excuse me. I retired from my position as a bureaucrat in California last year and joined WHO as of April of—

let's see, this is 1988—last year, so I have been involved totally with the Global Program on AIDS activities, and I——

Mr. BEREUTER. Do you have any impression, Dr. Chin, if it is an increasing amount that is going to AIDS out of the total WHO budget?

Dr. CHIN. No. As I indicated in my testimony, the bulk of the Global Program on AIDS funding is from extrabudgetary funds, so that it does not come out of the WHO budget. We have received facilities. We have received administrative support, and if you put a dollar amount on that, that may be $1 or $2 million, but the bulk of our support has been by extrabudgetary contributions from countries like the United State and other countries.

Mr. BEREUTER. Yesterday I amended the authorization bill for the multilateral development banks in a banking subcommittee. It will hopefully be coming to the floor soon. It takes advantage of a recent IRS ruling which permits debt to be swapped for charitable kinds of activities or in protecting environmentally sensitive areas, so if the human welfare were an ecological development swap it could be handled in several ways, including the debtor country in Africa paying in local currency or dedicating land.

In this case it seems to me that in the area of health and human services you might have the potential for the swap of a significant amount of debt, getting a tax writeoff here by the holders of the debt, in exchange for an acceleration of the AIDS control program, for example. What do you think the priority would be among African nations for devoting that new debt reduction opportunity to the area of AIDS and to health generally? If you can divide them, AIDS and then health generally, what would be their priorities if they had an opportunity to reduce their debt in that fashion?

Dr. CHIN. Now would this be in the form of a loan or in the form of a grant?

Mr. BEREUTER. No, it's a writeoff of debt, and it simply ends up as being a contribution, in effect, by the debt holder to that nation for activities that are deemed to be charitable under the IRS ruling.

Dr. CHIN. I'm afraid I will have to sort of almost take the fifth on that, because I have difficulty even in figuring out my U.S. income tax, let alone trying to see how African countries would think in terms of your particular legislation.

Mr. BEREUTER. Maybe you wouldn't have to take the fifth if I simply ask what I mean in the way I mean to ask it: What will be the priority, in your estimation, among African nations for dealing with AIDS, as opposed to other diseases and as opposed to environmental or development needs? How big a problem do they perceive it to be at this point, and how much does that perception vary across sub-Saharan Africa?

Dr. CHIN. OK, that I can grapple with. I think that when you talk about sub-Saharan Africa, you are really talking about—you are not talking about a homogeneous situation. You have countries like Uganda, and I would sort of differ with the chairman, that Zaire does have a fairly aggressive program——

Chairman LELAND. I am happy to be corrected.

Dr. CHIN. Well, I don't know what portion you saw, but at least within the public health circles we recognize Zaire and Uganda to be in the leadership area in terms of at least how far their programs have progressed. I think we have clearly ways to go with other countries. There are still some countries where there are still, at least at the high levels in the ministry, denials that a problem exists, so that I am sure this will be treated differently in different countries.

Priority, if we ever get extensive spread into the rural areas, I think then I would say that all countries will consider it the highest priority. At the present time it is still somewhat focused in urban areas, and in some sub-Saharan countries the numbers of cases and the numbers of infections are still relatively low compared to other countries in the area, so it is not a uniform picture by any means.

Mr. BEREUTER. And so the most urbanized of the countries are more likely to place a higher priority on it? That would be a generalization that would true?

Dr. CHIN. That's correct. That would be my opinion.

Mr. BEREUTER. Thank you, Mr. Chairman.

Thank you.

Chairman LELAND. Mr. Penny.

Mr. PENNY. I don't have any questions.

Chairman LELAND. Mr. Panetta.

Mr. PANETTA. Thank you, Mr. Chairman.

Dr. Chin, if Uganda and Zaire are at the top of the list in terms of their efforts to deal with AIDS, and Uganda projects a doubling of their AIDS victims over a 6-month period, I guess my question would be: What is your outlook for the rest of the African continent in terms of dealing with the AIDS situation?

I mean, you know, the fact is the United States is having a hell of a time dealing with the AIDS crisis with all of our resources. If you then look at those countries, Third World countries that have a tremendous challenge in terms of just feeding their people, survival, poverty, lack of education, disease, all of the other problems that face them, and now there is a whole new problem, a whole new epidemic is flowing into these countries. What is your outlook?

Dr. CHIN. Well, let me just say that it is difficult to even measure the actual, say, prevalence of both clinical disease and the level of infection that we have. We are beginning to get studies to give us a sort of sharper delineation of the problem, but then to perhaps forecast what future direction, say transmission of HIV infection, what that will take, I think it is unpredictable. For the same reasons, say in the United States, whether or not there will be extensive spread among heterosexuals in the United States will dictate whether or not the problem will grow even greater than it is now.

As I said, if the problem is essentially limited to urban areas in Africa, I think that the problem now is being somewhat defined and limited because you are talking about individuals with risk behaviors, and in urban areas there are so many people that have risk behaviors, multiple sexual partners. Those individuals, if they continue those behaviors without any protection, they will get infected. I think a very large proportion of the sexually active urban population in some of these cities have already been infected.

Now the rest of the adult population is not necessarily at risk if they do not engage in those types of behaviors, and I think we are seeing perhaps education beginning to pay off. Where an individual, say 5 years ago, may have had multiple sexual partners, they may now be limiting. They may now be using condoms.

On that basis, I think the outlook for the decrease in infections, even in the urban areas, I think is beginning to slow, although we don't have any evidence of that. I think that is the whole direction that the programs are trying to go to, and we can't measure that just yet because we are still having difficulty measuring what the current levels are, but I would say that from my own professional outlook, I am somewhat optimistic that we can bring it under control if we aggressively sort of pursue the educational area.

Mr. PANETTA. Well, based on the resources that you have now and that are committed to this issue at the present time, if you look at the next 2 years, is this problem going to get worse or is it going to stabilize?

Dr. CHIN. The problem definitely will get worse because I think the major numbers of AIDS cases that will be developing over the next 4 to 5 years throughout the world, and this includes the developing world, will come from those individuals that have already been infected, so that we can see clearly in the United States—even though there is data to indicate that the incidence of new infections, say among certain risk groups, the gay population, has slowed dramatically—we still will see maybe a four- to fivefold increase of AIDS cases by the early 1990's. Similarly, in sub-Saharan Africa over the next 5 years we can confidently predict that there will be at least a four- to fivefold increase over the numbers of cases that have already occurred.

The problem is that that is the nature of the natural history of this virus. These infections are incubating at the present time. There is no way that, unless we come up with the magic bullet in the interim, that we will be able to respond to that, so we have a clear problem of trying to respond and cope with the dramatic increase that we will be seeing in AIDS cases in the urban areas and many of the cities in central Africa. Beyond that, I think it is whether or not there will be infection continuing at a very, very rapid rate and whether or not there will be transmission into the rural areas.

Mr. PANETTA. In the areas that you have looked at in Africa, is the major problem heterosexual with regards to transmission of AIDS?

Dr. CHIN. Correct.

Mr. PANETTA. Thank you.

Mr. MFUME [acting chairman]. Dr. Chin, let me also thank you for your testimony and the forthright manner in which you presented it. It is obviously helpful to the members of this committee. Let me congratulate the World Health Organization for bringing you out of retirement and resurrecting you as a nonbureaucrat these days to help them in their policy formation.

I would like to ask just a couple of questions perhaps you can comment on, briefly or otherwise, one of these goes back to the spread of the disease. I think we all will agree that in many developing and nondeveloping countries, for that matter, the spread of AIDS is too ofttimes facilitated by inadequate blood screening procedures and policies and measures, and that as a result of that it is further spread through transfusions. Give us an idea of what the World Health Organization is doing to establish adequate blood screening procedures and policies in many of the nations in which you are involved.

Dr. CHIN. Well, OK. As I indicated in my statement, one of the first priorities in sub-Saharan Africa was to provide sort of the technology for HIV screening for blood, but looking beyond that sort of immediate need, I think that the Global Program on AIDS has seen that we do not want to go in for any quick fixes. HIV is just but one of the problems of safe blood. I think in Africa we would think of syphilis testing or hepatitis B testing, as something that is essential, not just HIV testing.

To that end, the Global Program on AIDS has recently convened and begun an initiative, along with other agencies, called the global safe blood initiative, which will try to look at blood throughout the world, but focusing on the developing world, in terms of safe blood, but safe not just for HIV, but safe for other infectious disease agents, and also at the same time to try to develop a comprehensive safe blood transfusion system. So we would take this opportunity, using AIDS as basically the foot in the door, so to speak, and using it as the immediate priority, to go in and begin to develop the necessary infrastructure to develop an adequate blood banking system.

Mr. MFUME. Tell us, how does the World Health Organization, in some countries where there has not been the sort of enlightened approach that we see in Uganda, what do you do in those nations as an organization to educate and to disseminate information, given the fact that many of the health delivery systems are poor or nonexistent in some areas, and certainly communications systems and the delivery of information through communications systems is difficult. Is there a plan or approach that you bring to those sort of nations?

Dr. CHIN. That is a difficult question because WHO is an international organization, not a supernational organization, so we provide assistance really at the request of member countries. We would respond to their request, but if a country for whatever reason decides not to make a request, it would be difficult for WHO to work within that country.

Mr. MFUME. And so if country A makes a request and admits, "Well, we have a problem that has gotten beyond our ability to grapple with it, and we would like for you to come in because we believe that we have to find ways to disseminate information and to take advantage of whatever health delivery systems there are." What then would you do? Would you come in and do an assessment of the nation's ability in those two delivery systems, and then make recommendations or approaches? Or do you come in and do that and jointly, at the same time, have a list of standard recommendations or other things that can be implemented right away?

Dr. CHIN. I can say that over the past year we have been learning. We have been learning from a lot of our mistakes, but I think one of the things that we have prided ourselves on doing is making mistakes of commission rather than omission. I think we are trying to learn what is effective, but if a country requests assistance, we have had sort of a standard package of making sort of the immediate initial assessment, in terms of what can the country usefully use, what does it need immediately, and then while that is provided to then have a fairly more broad sort of evaluation as to what this problem is, what is needed to address the problem, and then to develop the medium-term plan. That has been a system that I think has been working well. I think that the medium-term plan development is still evolving, so that we still are learning in terms of how to perhaps draft up national AIDS plans.

Mr. **Mfume**. Let me in closing go back to a question that I put to the Ambassador who preceded you, and to ask you if the World Health Organization—given the fact you have vast resources in terms of researchers and scientists and others who go, I think, about the process of assisting in research and development and testing and setting up models and demonstrations—have you or your forecasters, as best you know, looked at the situation not just in one or two countries but perhaps worldwide, or let's say in the Third World, and are able to project or anticipate or forecast a period in time at which we would be able to notice a leveling off if not a decrease in the rate of infection in those nations, cumulatively?

Dr. **Chin**. Well, my basic responsibility within WHO's Global Program on AIDS is surveillance, forecasting is the middle part of it, and impact assessment. I feel that at the present time, with the knowledge that we have of the natural history of HIV and about transmission patterns, we can make short-term predictions only. That is, we can make predictions about the numbers of AIDS cases that will be occurring over the next 4 to 5 years. To try to go beyond, say, a 5-year period, I think is very difficult because of all of the factors that I have mentioned.

Whether human behavior will change, whether education will be sustained, whether national commitments will continue, all of these variables will dictate whether or not there will be further transmission. To predict say 10 or 20 years in terms of human behavior I think would be very, very dangerous. I know that weather forecasting is a much more developed science, and I think that they have difficulty predicting long range. I would say anybody that would try to predict 10 or 20 years for a situation like HIV, you can hear it but the range of that prediction I would have very little confidence in.

Mr. **Mfume**. That is one of the things, I think, that frightens so many people, is that you have to factor in so many different variables, and while the world is looking and anticipating and hoping, really, for some sign on the horizon that change is forthcoming, it is just very, very difficult. I didn't have any idea. Everyone I asked says essentially the same thing, that there are just too many things that have to be factored into the equation.

I certainly want to thank you for appearing before the committee. Your testimony has been quite helpful. Thank you, Dr. Chin.

At this time, if there are no further questions, the committee would like to call its next witness.

Dr. **Chin**. May I just make one last statement?

Mr. **Mfume**. Yes, sir.

Dr. **Chin**. I think that one thing that has been clear, one thing we can continue to predict, is that individuals who do not have risk behaviors like multiple sexual partners or sharing needles, or blood, once we get the blood transfusion situation sort of fixed, those individuals—and that is the majority of the world's population—is at no risk for HIV. It is just those individuals who persist in those risk behaviors, and we estimate that worldwide there may be several hundred million individuals with those types of risk behaviors. Our task is to focus on those individuals, not the whole population but on those individuals, to get them to modify or eliminate their risk behaviors. So I think there is optimism in the sense that not everybody in the world is at risk of exposure, only those individuals that have these high-risk, HIV risk behaviors, remain at risk.

Mr. MFUME. But I noticed that, in reading the Ambassador's testimony, that in his nation I think the population group 5 to 14 showed no infections at all. They represented 50 percent of the population and represent, I think, a tremendous opportunity to be able to affect that population group while they are in their formative years, so that we can in fact curtail the spread of the virus.

Thank you again, Dr. Chin. I appreciate it.

The Chair would like to call Mr. Bradshaw Langmaid.

We are pleased to have with us today the Assistant Administrator for Science and Technology at A.I.D. and chairman of the agency AIDS Working Group, Mr. Bradshaw Langmaid. We have enjoyed Mr. Langmaid's testimony at the previous hearings on child survival, and look forward to hearing from him today on A.I.D.'s program efforts to control the spread of AIDS.

Welcome, Mr. Langmaid. We are glad that you could be with us today. If you could present a brief summary of your testimony, your entire statement would be entered into the record and, as always, we will have some questions to follow.

STATEMENT OF BRADSHAW LANGMAID, DEPUTY ASSISTANT ADMINISTRATOR, BUREAU FOR SCIENCE AND TECHNOLOGY, U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT (U.S. A.I.D.), ACCOMPANIED BY JEFFREY HARRIS, M.D., AIDS COORDINATOR

Mr. LANGMAID. Thank you, Mr. Chairman. If I may introduce on my right Dr. Jeffrey Harris, who is the AIDS coordinator for the Agency, I will ask him to handle some of the more technical questions if there are any.

Mr. MFUME. Sure.

Mr. LANGMAID. I have provided a relatively brief statement, Mr. Chairman, but also included in that is a copy of the Agency's most recent report to the Congress on AIDS, which is a rather extensive treatment of our entire program and our understanding of the situation, so I will really, given the time, be very brief in my opening comments.

I think, first and foremost, my agency enthusiastically and vigorously supports the leadership of WHO as given on the international AIDS effort. The United States provided financial support, as has been noted already, personnel resources to WHO and diplomatic leadership to this WHO program. Our collaboration and coordination with WHO in this area is close and continuing.

Second, I would emphasize that we are determined to ensure that our health and population programs do not themselves contribute to the spread of the virus and are protected from infection. A number of questions have come up in that area. I would be glad to answer further any issues that may arise.

Third, in this emergency there is no time to build new organizations. Each contributor should operate where its comparative advantage is greatest. Our institutional strengths, we believe, are in training and technical assistance. In health and population, we believe we have particular strengths in service delivery.

Finally, I need to emphasize that there are some areas of the problem that are beyond AID's capabilities but which are much more the responsibility of others. For example, we do not intend to be involved in curative care, nor are we planning investments in basic research for a vaccine or a cure. Other agencies of the U.S. Government or the private sector are far better equipped and organized and funded to address these critical problems. However, we take seriously our legislative mandate to ensure that the research in these areas is effectively coordinated so that the results of this research are made available to the developing world as rapidly as possible.

Thank you, Mr. Chairman, and I would be glad to answer any questions you may have.

[The prepared statement of Mr. Langmaid appears at the conclusion of the hearing, see p. 65.]

Mr. **Mfume**. Thank you very much, also. I would like to begin the questioning by asking if you would state for the record and certainly address the committee about the long-term objectives of the Agency's fight as it relates to AIDS and what you are trying to do there, what you hope to do, and what short-term objectives have been established by the Agency related to that.

Mr. **Langmaid**. In almost all respects, our objectives are no different than those of the WHO/GPA, which we support with half of our overall funds. Clearly, to deal with this problem, behaviors have to change. Our objectives would be to ensure that there is a safe blood supply in the world; that immunization programs, other similar kinds of programs, are not a method of transmission; but beyond that one has to deal with behavioral change, which really deals with educational activities. As Dr. Mann has said many times, the solution to this problem is education, education, education, and that is a very difficult problem to deal with, and the behavioral changes are very difficult to deal with, but at this moment those are the options that are available to us in dealing with the problem.

As I look to the future, clearly I would hope to see our support rise with the support that WHO needs to carry out the GPA, the general program. There are also a number of areas of particular aid, investment, and concern over the years in health and population and child survival which will need continuing attention as part of the AIDS effort.

Mr. **Mfume**. Mr. Langmaid, would you take a few moments and sort of detail, if you could, the coordination of A.I.D.'s efforts with the World Health Organization's Global Program on AIDS?

Mr. **Langmaid**. The coordination really takes three forms. One is close and continuing headquarters coordination. Either I or Dr. Harris have been to Geneva many times over the last year to 18 months since this started, at the participating parties meeting, which is their organizational program, as well as at staff level consultations.

In addition, the principal implementation agents for us in this program are two contractors, Family Health International and the Academy for Educational Development, working in the twin areas of technical assistance and education. They have been making field trips to posts, on request from those posts, and in almost all cases their technical people stop in Geneva on the way back, debrief the GPA people on what we are doing. In turn, GPA people meet with them and debrief on what GPA is doing.

Last, at the country level A.I.D. has been represented at virtually all of the national AIDS pledging sessions. We have committed funds to all of those, and at the mission level, working with the national AIDS committees, we work daily with both GPA expertise as well as our own expertise in the national committees. We enthusiastically support the approach of the GPA, that there be national AIDS committees which act in a coordinating role for all donor activity, and we work within that environment.

Mr. **Mfume**. A.I.D. has committed over $43 million, I am told, for two consultants to carry out programs. If either of you could comment on this, few of the funds are left for PVO's that have the experience and have the contacts to carry out the program. To what extent are funds committed, and how do you expect to be able to include more PVO's, or have you anticipated how you might do that?

Mr. **Langmaid**. The level you mention, Mr. Chairman, is——

Mr. **Mfume**. Is that a correct level, by the way?

Mr. **Langmaid**. It is over 4 or 5—is it 4 or 5 years?

Dr. **Harris**. Five.

Mr. **Langmaid**. Five years. It's a 5-year level for both, just on an annual level.

Mr. **Mfume**. I see.

Mr. **Langmaid**. The funds the Agency has for bilateral activities are $15 million a year, under the current budget of a total of $30 million, $15 million for bilateral, of which $3 million is provided for the funding of condoms, so the total amount in an annual program sense is much smaller.

The two firms I referred to, both of which are nongovernmental organizations, they are not-for-profit foundations. One is Family Health International, which frankly runs a number of AIDS programs worldwide with its own resources, let alone ours, and the other one is the Academy for Educational Development, which is also a nonprofit organization. It also runs a number of educational activities around the world. So I am not sure it is fair to characterize them directly as only paid consultants. They have an institutional commitment to this problem which is beyond the kinds of investments we are making in them.

The funds that we are providing for bilateral activity, we have reserved around $500,000 for what I would call seed grants to PVO's, to provide them technical assistance as necessary and other support for their becoming involved in the AIDS problem. In addition, a substantial portion of our funds, as the Africa Bureau's own project will support, go to individual country missions. I fully anticipate that those mission funds will in turn be provided for local institutions, PVO's, nongovernment organizations.

I just came back from the Stockholm International AIDS Conference, and I think one of the impressive things one has to see at that conference was the role of local-based, very small, very vibrant, local-based institutions dealing with the education problem. There were some unbelievable reports from one researcher in the Ivory Coast, using local patterns of theater for education and young children as the actors in that theater, as tools for AIDS education. There was an equally dynamic presentation by a researcher working in Worcester, Massachusetts with a rap video, the most powerful thing I have ever seen in communicating at a teenage level on the AIDS issue.

It is that energy that is going to have to be brought to bear on the education problem. You are dealing with the most sensitive, most private kinds of behavior, the most culturally specific kinds of behavior, and we thoroughly support and would intend to support financially the kinds of community involvement that bring that behavior and the educational programs together. It has to be done that way.

Mr. **Mfume**. What are the criteria that your Agency uses in terms of the level of funding, the level of appropriations, the amount of resources to be targeted in a given country, let's say? I mean, do you look at projections on the spread and transmission of the disease? Do you look at population density? Do you look at GNP? Do you look at who is requesting it and who is not? I think 143 nations have requested some sort of aid; 121 have received it. I would just like to get an idea of the things that form, at least, your selection process.

Mr. **Langmaid**. We tried, early in this process, a "black box" approach where we fed a whole bunch of data into computers to see what it would look like, and it has had some value in trying to sort out the different priorities. Clearly the No. 1 priority has to be either the existence of infection or the risk of rapid spread of that infection, and the second criterion I think has to be the impact that will have nationally on the society. That takes you very quickly to those societies which have a high level of infection, have a major urban population, or are on major transportation routes that would bring them at risk of major spread.

After that, one has to look at the resources available from other sources, the capacity of the government to use resources, and I would emphasize, which Dr. Chin did, the commitment of the government to use those resources. If a country is not prepared to acknowledge or direct its own priorities on the AIDS issue, there is very little we can do to help them until they have developed that awareness.

Our programs reflect that priority. Uganda is the highest aid recipient among the countries receiving assistance under our program. I think Zaire, Rwanda, a few others which have a very high level, come next in order. We haven't talked about Central America at all today, Mr. Chairman, but clearly Haiti and also I think

Barbados are problems, have infection rates comparable to some of the high levels in Africa, so there are other parts of the world with the same kind of issue.

Mr. **Mfume**. Well, Mr. Langmaid, I want to thank you for coming and offering your testimony today. Offer my appreciation to A.I.D. for acting rapidly, at least in this past year, criticisms notwithstanding, to develop an AIDS policy and to seek to develop programs to implement it.

The Chair or the committee may in fact have additional questions. If so, we will submit those to you so that you could get back to the committee. We would make that part of the permanent record, but again I want to thank you very much for appearing, and thank you, also.

Mr. **Langmaid**. I will be glad to, Mr. Chairman.

Mr. **Mfume**. The Chair will recess for 15 minutes, after which we will being with our next panel, and we ought to be reconvening at about 20 of the hour.

[Recess taken.]

Chairman **Leland**. Let me ask if the administration representatives will please hold on for a few more minutes.

Mr. **Langmaid**. Sure.

Chairman **Leland**. Mr. Langmaid, you mentioned, as I understand, that the Agency's funding for AIDS programs would include not only funds from the AIDS account but also funding from the health and population accounts, the Economic Support Fund and the Development Fund for Africa. Could you tell us roughly how much you expect to come from these accounts and how that money will be spent? Will decisions on these matters be made on an ad hoc basis, or is there some policy on how funds from other accounts will be used on AIDS? I feel that decisions must be made now, in the relatively early stages of the epidemic, on how funds from other accounts will be used to support AIDS efforts. Is there any such policy in place?

Mr. **Langmaid**. Mr. Chairman, the position that the Agency has taken in sort of the management of this program is that the AIDS funds for the AIDS account are for designated AIDS activities, activities which are undertaken solely for the purpose of dealing with the AIDS problem, but AIDS is not a distinct problem. It is a health problem. It is a population problem.

There are a number of Agency activities around the world, as you well know, child survival being a principal one, which have some degree of interaction with the AIDS issue. They need to be protected from the AIDS issue. It hasn't been mentioned so far, but other sexually transmitted diseases are probably the most powerful cofactor in the spread of the disease and will need to be dealt with if we are going to bring the spread of the disease under control. Our population account has been the principal area of funding for our sexually transmitted disease programs over the years.

We have taken the position that where it is necessary in those ongoing programs to add a component to protect them in terms of transmission—add a training syllabus on the STD clinic, dealing with the AIDS issue; add additional supplies of clorox to clean the needles; add more training for nurses on how AIDS is permitted, as part of an old MCH program—those costs must be borne, should be borne, by the ongoing program. It makes no managerial sense to split the AIDS $15 million into $5,000 here, $2,000 somewhere else, $15,000 somewhere else. Managerially it doesn't make any sense and programmatically it doesn't make an awful lot of sense.

That makes it difficult for me to tell you straightforwardly what the amounts are, but in fiscal year 1987 it was something around $2 to $3 million as the reports came in of what missions had spent that could be identified as AIDS, in addition to the money we had set aside. We expect in fiscal year 1988 that number may rise to around $5 million. I think if one looks to 1989, it is conceivable there could be a slight increase over that, but that is sort of the policy position we have. It is not neat and clean, but the distinctions between—take the obvious case of condom supplies—between condom supplies dealing with the AIDS issue and condom supplies dealing with the population issue, I can't make that distinction, and it is equally difficult in some of the other areas. I think it is a workable, pragmatic approach.

Chairman LELAND. A.I.D. has always had a good working relationship with the PVO's in dealing with problems in the Third World. There is considerable agreement that PVO's can be an invaluable resource in helping to solve the problem of AIDS in Third World nations. Both Congress and the administration have arrived at that conclusion. What is your opinion about that, and to what extent does A.I.D. expect to pursue that avenue of campaigning against the AIDS crisis.

Mr. LANGMAID. I couldn't agree with you more, Mr. Chairman. As I said earlier, I spent 3 very hard days a week or 10 days ago in Stockholm at the International AIDS Conference. For me, as a nonmedical professional but a program manager, the most powerful lessons coming out of that conference had to do with locally based education efforts designed on a peer group basis to deal with preventing the spread of the disease, educating people on the methods, changing behavior. The successful ones were all predicated on very specific, localized community action kinds of activities. The PVO's pioneered that kind of work.

If you look at what is happening in the United States, a whole range of new groups are emerging, dedicated to the AIDS issue, and they are having a significant impact on changing people's behavior in the United States. I fully expect that to happen overseas. I saw a very dynamic program, I think it was from the Ivory Coast, where the principal means of education is really local theater, family theater almost, and the local organization was developing AIDS-specific theater programs, with the children of the village putting on the presentation. That gets messages across in ways which no other kind of system could, and a government agency is not the one to do that.

So I see the PVO's playing a major role. I see frankly, even more important, local institutions, some of which don't even exist at this moment in time, because it is going to have to be locally based. You are dealing with an issue of such local sensitivity, such privateness, that the local customs are going to have to dictate. We can help them on how one samples results, but they are going to have to dictate the messages and how those messages are received.

This year we have done really two things—three things, I would emphasize. I have been to at least two national PVO meetings to talk about what our program and policies are and elicit their input into what we are doing. Dr. Harris has been to several more than I have.

We have put a $500,000 program into place which is a competitive grants program, really designed to seek capital for those PVO's who are interested in getting into the AIDS business, who feel they need technical assistance and training in either communications or other areas. In addition, we are setting in place regional projects to provide money at the field level to missions for the national AIDS programs, and we would expect PVO's to play an active role, as they already are in some cases, in those national AIDS programs, and it will be funded through mission allocations.

Chairman LELAND. Let me ask you, do you expect the same kind of formal engagement with the PVO's that you had, particularly in the efforts to provide humanitarian aid to the hunger-stricken parts of Africa during the drought in 1984–85?

Mr. LANGMAID. I personally am not that familiar with the African organizational experience. The PVO community has been an active member of the GPA participating parties, which is the oversight committee. That involves both donors and PVO's. That has now been slightly reorganized, and all the donors have been urged to include PVO representatives on their delegations to the meetings in the future. We clearly intend to do that.

I would welcome a structure which would enable us to interact in a little more than one-on-one basis with the PVO's, so we can truly understand better what their overall problems are and what kinds of programs are most useful. I was hoping, out of some of the discussions we had with the national meetings, that such an AIDS-focused would emerge that we could deal with. Right now it is primarily 1 on 1 with individual cases, except at the country level, but I would welcome some kind of a more structured way of interacting with them.

I am struck, and maybe it is because it's so new, that the groups that are now becoming involved in the AIDS issue, both in the United States and overseas, there is a large number of NGO's which are not part of the historic PVO community, and frankly some of the more historic ones are dealing with AIDS as part of child survival or population or regular health but have not yet decided to commit themselves to AIDS-specific kinds of interventions. It is a difficult political choice for them.

Chairman LELAND. I understand. I understand that earlier this year WHO launched a worldwide effort to safeguard blood from contamination by the AIDS virus. What has A.I.D. contributed to this effort? How do A.I.D.'s separate efforts on blood banks fit into this worldwide effort?

Mr. LANGMAID. We were a party to the—the WHO is forming, in a sense, a consultative arrangement of both private and governmental organizations interested in a safe blood supply. We are part of that. We would expect to contribute to it. In addition, through our projects we have provided blood screening materials to a number of developing countries. We are also a major supporter of an effort to identify low-cost, easily applicable blood tests, which will be of critical importance to countries developing a safe blood supply, so we would plan to be and have been a major player in that program.

Chairman LELAND. So you are working in tandem with WHO?

Mr. LANGMAID. That is correct.

Chairman LELAND. But at the same time you have separate programs going.

Mr. LANGMAID. At the same time in some countries where we are pledging, as part of a WHO-approved country plan, we may well pledge the blood screening portion of that and WHO will put its money somewhere else.

Chairman LELAND. Let me ask you something. There is a hospital and a relative medical school researching how to zap, if you will, the AIDS virus from blood supplies. Are you familiar with that at all?

Mr. LANGMAID. Let me turn to Dr. Harris for that one.

Dr. HARRIS. Actually I don't have a lot of familiarity with that at all. We have taken the tack of using the existing technologies, and in fact furthering the existing technologies to make them more useful in developing country environments. We have taken the existing ELIZA technologies and taken the machine out of the process, made it so that they can be done without electricity at all, and we presented in Stockholm the first comparative trial of five such tests that was done in Kinshasa.

Chairman LELAND. I would like very much to get you the information on, I think it is Baylor Hospital in Dallas, if I am not mistaken. My colleague Jack Fields, who represents Houston, sits on the Baylor College board, and he has indicated to me that there was this kind of program and wanted to know if I wanted to try to extend some opportunities to African nations to utilize this, and I am sure that it is certainly in an experimental stage at this time.

Dr. HARRIS. Well, I can pursue my own channels. I actually graduated from Southwestern in Dallas, so I can——

Chairman LELAND. Well, right on. I'm glad you have some Texas roots. You're a good man. Keep coming back. [Laughter.]

Mr. Langmaid, one of the two major bilateral programs at AIDSCOM—I hope I am pronouncing that correctly——

Mr. LANGMAID. That is correct.

Chairman LELAND [continuing]. Is supposedly using lessons learned in the United States from social, marketing, and behavioral analysis to help developing countries with AIDS education efforts. Many observers have expressed concerns that the U.S. experience is not necessarily transferable and that the contractor carrying out the project doesn't have adequate experience in the developing world to make the program appropriate. Can you just comment on that?

Mr. LANGMAID. I certainly will. I will be glad to put that issue to rest. The contractor is the Academy for Educational Development, which is the organization principally responsible for all the success in the health communications programs in the child survival area, as well as most of the commercial marketing activities in the population area before that. I don't think there is any question as to their qualifications.

I would agree with the earlier part of your statement, Mr. Chairman, in terms of the care with which one replicates the U.S. experience. I think the messages are very different, the way they are received is very different. Even within the United States one has to be careful in terms of who your audience is. The message delivered to some parts of the country—I happen to be from Boston, and I am not sure I am understood outside of the Boston area, given my own accent—but the message, the language, is different and you have to adjust it to that, so I don't think there is any question there.

I think the lesson you bring to the Third World has to be equally culturally specific. You have to go through the same processes of understanding how communications occur in the developing world. I didn't know, for example, that probably 80 percent of the information brought to the village level in some African countries is brought by the youngest child, who happens to be in school, but as the only person who is in school that child has a habit of coming back and reporting on what has happened during the day and what they have learned. One has to target on that avenue of communication, so really that is the lesson to be learned, not to take the message and directly apply it to a Third World setting.

Chairman **Leland**. We certainly appreciate that kind of sensitivity. We found that—not A.I.D., because you are experienced—but so many of us tend to be so chauvinistic about how we approach these programs. We tend to believe that our way is the best way, even in communicating to other folks, and that certainly has not proven to be the case. I recall when 20/20 and Nightline were created. They were created out of the crisis in Iran when the hostages were held there, and we realized, when we were trying to analyze the circumstances and determine why the folks would do what they were doing, that we knew absolutely nothing—if anything at all, very little—about Iran, about the people, their culture, their language, and their history. Until we learned about that, could we communicate at all with them? Of course not.

Mr. **Langmaid**. As a development specialist now over 25, 26 years, I have learned in dealing in the Third World you listen very carefully to what they say, but also to all the body English that goes along with what they say.

Chairman **Leland**. One last question: Could you tell us about the Africa Bureau's HIV/AIDS Prevention in Africa, or HAPA project, and how will this differ from the current AIDSTECH and AIDSCOM programs?

Mr. **Langmaid**. At risk of making my African colleagues unhappy with me, I think the project has two components. The reason for the project really is to find a management device within our own Agency to move money out to the field for country programs. There are some activities which can only be funded centrally, and they will be funding some of those, but most of the funds under that project will be reallocated directly and obligated as part of country missions.

This is really a device for facilitating that kind of country level program. The Africa Bureau believes quite strongly, and I think correctly, that these decisions have to be made in the context of the national AIDS program and the country priorities. This is their management device, if you will, to put the funds in the hands of missions to commit to those kinds of programs. Many times those funds will in fact be then used by the mission to purchase goods and services from some of the PVO's or from the AIDSCOM and AIDSTECH activities, so it is a funding device rather than a substantive—it is not a competitive activity with our own.

Chairman LELAND. Very good. I thank you very much. I thank you for your continued support of this committee by way of your involvement.

Mr. LANGMAID. Delighted to be helpful, Mr. Chairman.

Chairman LELAND. Thank you very much. Thank both of you.

By the way, I must say that to provide some collateral interest, I am happy that the young man with you, the doctor, has some experience in Texas, but my wife is from Boston, so you guys are both good guys to me.

Mr. LANGMAID. I can talk to him. I'm assuming you can discuss with your wife.

Chairman LELAND. We will next hear from Dr. Michael Gerber, president of the African Medical and Research Foundation or AMREF. AMREF has taken a strong initiative in devising health efforts to slow the transmission of AIDS in Africa. Dr. Gerber and I had the opportunity to discuss the impact of AIDS on development in the Third World at a previous hearing this year. I am glad to be able to hear from him once again.

Welcome, Dr. Gerber, and thank you for being with us today. If you could just proceed with your statement, we would appreciate it.

STATEMENT OF MICHAEL S. GERBER, PRESIDENT, AFRICAN MEDICAL AND RESEARCH FOUNDATION

Mr. GERBER. Thank you, Mr. Chairman.

As you said, I come before you representing AMREF, the African Medical and Research Foundation. AMREF is a private voluntary organization with an operational headquarters in Kenya. The staff totals nearly 650, of which over 90 percent are African. We work in a number of eastern and southern African countries. Written testimony has already been presented which reflects on a variety of issues. These include a survey of AIDS in Africa, comments on the sensitivity of AIDS in Africa, and some specific AIDS programs that AMREF has been involved with for the past 2 years.

In the brief time I am here today, I would like to highlight three areas. These are: the impact of AIDS on development; the need to integrate AIDS interventions into comprehensive health programs; and the role that PVO's can play in the efforts to slow transmission.

I am sorry your colleague from Nebraska has left, because I was going to invite him at the end of my testimony to re-ask the question about debt and possibly debt swapping. I think from the point of view of a U.S.-registered private voluntary organization, we have some very concrete ideas, as do members of other PVO's, in terms of how debt can be used specifically for social services and health interventions.

The consequences of AIDS go far beyond health statistics. Given the heterosexual nature of transmission and the 1 to 1, female-male ration of HIV infection, the economic and social effects may be critical in a number of African countries. Deaths from AIDS will occur among the sexually active, which usually includes those in the 20 to 45 age group. However, the growing number of teenage pregnancies in countries such as Kenya, Tanzania, and Uganda, as well as others where we are not active, attests to a broader sexually active range, perhaps 15 to 45.

Most other diseases in the developing world largely kill the very young and the very old. AIDS has the potential to raise mortality rates several-fold among the economically and socially most productive age groups. Developing nations stand to lose people who are their greatest resource. AIDS will no doubt seriously hamper both industrial and agricultural production if it spreads from the urban areas to the rural areas. Given the subsistence, labor-intensive agriculture in many African countries, food production may be significantly reduced. The implications for standards of nutrition are also obvious.

In most African countries trained manpower is already in short supply. Certain industries stand to lose key personnel. A sample of workers in a central African mining town, taken in 1986, showed 68 percent of skilled male mine workers testing positive for HIV. Contract workers in industry and agriculture are extremely vulnerable. Many work away from their families and indulge in casual sex or visit prostitutes. AIDS epidemics in export industries could possibly affect both potential foreign exchange earnings and international commodity prices.

The AIDS epidemic can be devastating to the traditional African societal structure. Given the lack of government resources in most developing countries, the extended family or group provides the kind of social security system that public support makes available in the developed world. In Africa the very young, the old, the sick and disabled are often totally dependent on the age group most at risk from AIDS. Some AMREF staff members recently visited a village in East Africa where 90 percent of the adult population of that village had died, and only young children and old people were left. This was a village where primarily the men had gone off to work in an urban area and had come back and probably had infected most of the women in the village.

The increased burden that AIDS will place on the existing health care systems in Africa will be far beyond the abilities of countries to cope. The annual health budgets in many countries range from $1 to $5 per capita. Some hospitals are today being flooded with AIDS patients. These hospitals are already overburdened, and the result is less care for those suffering from other illnesses.

A single blood test in Africa averages anywhere between $1 to $4, and the machine for testing blood samples can cost up to $15,000. The U.S. Surgeon General has estimated that annual health costs of treating AIDS patients in this country could reach as high as $16 billion by 1991. We already know the strain this places on America's vast resources. How can the much more limited health services of Uganda, Tanzania, or Kenya respond?

In some African countries, children comprise as many of one-third of all AIDS cases. The HIV epidemic could seriously affect gains made in infant mortality and child health, the recent child survival program. The epidemic among children can be attributed to a number of factors, which include as many women being infected as men and very high birth rates.

Perinatal transmission is the dominant route of HIV infection in young children. The infection can be transmitted to the fetus during pregnancy or to the newborn during delivery and possibly during a short time after birth. The virus has been isolated from fetuses, from cord blood at birth, and from breast milk. As many as 50 percent of children born to infected mothers are seropositive. Most of these children are dying within a year.

Since there is a possibility that transmission after birth can occur through lactation, concern over the promotion of breast-feeding has grown. However, the risk of effective transmission through ingestion of breast milk is not known, and most experts believe the many benefits of breast-feeding outweigh the risks. Both WHO and UNICEF continue to promote breast-feeding, as do we and other voluntary agencies.

As knowledge about the causes of AIDS becomes more widespread, there could be implications for child immunization campaigns. The reuse of needles is widespread in Africa, but to date in the areas where AMREF works there has been little or no resistance to injections because of a fear of AIDS. While the use of disposable needles is ideal, the cost factor makes such a strategy not always practical. It is more feasible to encourage the proper sterilization of reusable needles, although in hard-to-reach rural areas where much of the population lives, sterilization is not always easy because of scarce resources—water, fuel, et cetera. At this point in time, however, the risk of death remains much greater for those not immunized than for those who are.

I would now like to comment on AIDS programs, their content and the need for integration. For those of us actively working in Africa, there is a strong sense of urgency to quickly mobilize resources and begin a series of interventions. However, based on AMREF's experiences with AIDS in East Africa over the past 2 years, it has become obvious that a number of factors need to be in place before any organization can effectively intervene.

These would include a previous experience in and knowledge of the country or countries where projects or a project will be carried out; two, a working relationship with the ministry of health and other local indigenous agencies; three, evidence that planned interventions are consistent with and acceptable to the National Committees on AIDS; four, an ability to integrate AIDS projects into ongoing health programs that are already being carried out in-country. The above will ensure that AIDS efforts become integrated as part of comprehensive health programs and the existing infrastructure. And, last, a plan is needed for facilitating replicability in other parts of the country and region.

Program components should include interventions that impact on prevention, service, and a better understanding of the epidemiology of AIDS in the developing nations. Programs related to prevention should focus on health education for groups at risk as well as the general public, and involve training of all cadres of health and laboratory workers as fighters in the struggle against AIDS. In addition, applied research on the behavioral aspects of HIV transmission should be encouraged. Service programs might assist in the development of laboratories for testing, as well as designing approaches to managing the tremendous demands for care that are at once compassionate and provide for the survival and perhaps even strengthening of the existing health structure.

Epidemiological surveys should be aimed at collecting data in rural locations where PVO's traditionally have had a presence. There basically is very little or no data from the rural areas, and there is concern, based on mobility patterns, specifically of men going off to work in cities and coming back to the rural areas frequently, of a spread from urban to rural.

I guess what we are saying is that voluntary agencies, since traditionally they work in rural areas, probably could play a lead role in doing epidemiological prevalence surveys or at least help out in that area. Maximum value might be achieved if such data collection could be coordinated by specific leadership from the technically sophisticated epidemiology groups linked with WHO or present at various universities.

To begin having an impact on curbing HIV transmission, the need to immediately integrate AIDS interventions into broader-based health programs cannot be emphasized enough. In Africa there is a need to target both high-risk groups—namely, prostitutes and their clients—as well as the population at large. It will be necessary to use all existing resources and the infrastructure in place. To promote safer sex, all cadres of health workers must be utilized as motivators. This can be accomplished by incorporating AIDS education into ongoing training programs offered by ministries of health, ministries of education, and private organizations.

The linkages between AIDS, population, and family planning are obvious. The growing fear of acquiring the virus should result in the increased use of condoms and other barrier methods. The dual effect might be to increase the number of family planning acceptors and less likelihood of HIV transmission through sexual contact.

I would like to conclude with a few words on private voluntary organizations, which we feel are resources to be utilized. A limited number of private voluntary organizations have the potential to be valuable agents in the struggle against AIDS. In reference to the criteria I have previously stated for effective AIDS interventions, some PVO's do have proven track records in the countries where assistance is needed, previous experience in the health sector, community-based programs, an integrated infrastructure to support such programs, indigenous staff, linkages to local organizations, and an ability to work at national level.

There are PVO's which have 25 or more years of experience working in countries seriously impacted by the AIDS crisis. Some of them have been implementing health programs involving both direct delivery of services as well as health education and training. In Africa the voluntary agencies have tended to focus their programs on the rural areas, where over 80 percent of the continent's population lives. Most importantly, the PVO's have traditionally been community-based with strong ties at the grassroots level. Given the lack of data from rural areas and the need for community-based seroprevalence studies, as I mentioned before, PVO's might play an important part in determining the epidemiological scope of the AIDS problem.

Given the need to deal with AIDS in Africa on African terms, it is important to note that many PVO's rely on African staff members in the implementation of their projects. They also have strong links to indigenous nongovernmental organizations. With the key role being played by National AIDS Committees and the political implications of the AIDS problem, it is those PVO's experienced in working with central ministries of health and ministries of education that will be in the best position to respond to requests for assistance.

PVO's are ready to add AIDS work to their current health projects and community development activities. PVO demonstration projects should serve as examples to national governments and funding agencies by showing how programs to curb transmission can be organized and implemented in a timely fashion. Through funding of PVO projects, the data and resultant models will be culturally and geopolitically relevant.

The factor which has limited AMREF's AIDS interventions over the past 24 months has been a lack of funding. We have made major efforts to attract support from the private sector in the United States, but to date there has been little response to the international aspects of AIDS from the private sector. U.S. A.I.D.'s initial responses, which we have heard, were to the funding of WHO's global program on AIDS and the awarding of the AIDSTECH and AIDSCOM contracts. There was little opportunity for PVO funding.

AMREF has been most encouraged in the last few weeks by the announcement of the new U.S. A.I.D. Africa Bureau program, HIV/AIDS prevention in Africa, or HAPA program. Our understanding is that approximately $20 to $21 million will be allocated over 3 years to ensure that issues of AIDS prevention and control are addressed. The funds will be for intervention-related activities and applied research. We have been informed that PVO's are eligible to submit proposals for funding through HAPA, and that the U.S. A.I.D. missions in Africa will play important roles in determining potential implementors. AMREF applauds the Africa Bureau's efforts and, along with a number of PVO's, looks forward to cooperating with U.S. A.I.D. in the fight to curb the spread of this deadly disease.

Thank you.

[The prepared statement of Mr. Gerber appears at the conclusion of the hearing, see p. 101.]

Chairman **Leland**. Thank you very much, Dr. Gerber.

Let me ask you, in light of the final part of your statement there, do you know of other PVO's who are interested in getting involved in AIDS programs or who are involved but would like to appeal to A.I.D. to get funding and other resources from them?

Mr. **Gerber**. I can tell you three immediately that have been quite active. We have been in the forefront for the past 2 years. World Vision has been quite interested and quite active in looking to expand their interventions with additional funding. Project Hope, although not so much in Africa but in Latin and Central America, has been very active in this area, and I think a number of others such as CARE and Save the Children, which have extensive child survival programs and health interventions, could very easily integrate various health education interventions as well as other interventions into their existing programs. I think those are the advantages I was trying to focus on, in the sense that we do have some existing infrastructures in which we can build in AIDS interventions.

Chairman **Leland**. Mr. Langmaid said that A.I.D. would like a more structured way of working with PVO's. Do you have any recommendations as to how this could be achieved. More than just contracting with a PVO here and a PVO there, is there a more structured way that you might suggest that A.I.D. ought to pursue?

Mr. **Gerber**. I haven't given much thought to that area. We would welcome that. I think we would welcome—and I would like to emphasize, I don't think a large number of U.S. voluntary agencies probably will get deeply involved in the AIDS issue overseas, and I try to stress in the testimony that there are a limited number because we feel very strongly that there must be some criteria for effective interventions, which I have laid out those criteria—but there are a number of us, and I have mentioned some by name today, that do meet those criteria, that do have those prerequisites, I think we as the PVO community would welcome sitting down with A.I.D.

The difficulty with U.S. A.I.D. from our perception, as I think is the difficulty from U.S. A.I.D.'s perception of the PVO community, is who to identify within A.I.D. We all tend to deal with local missions. We tend to deal with the Africa Bureau, we tend to deal with the Office of Health, and I think we probably need some kind of coordination between various elements within the Agency—the Africa Bureau, the Office of Health, various missions—and those PVO's that have some kind of specific capabilities to deal with this, and maybe sit down and work out some kind of mechanism.

Chairman **Leland**. I think very definitely, since Mr. Langmaid said today that he would be interested in at least looking at that.

Mr. **Gerber**. And I will go on record from AMREF's point of view, I mean, if they would like for us to kind of spearhead this and begin organizing the PVO community, we would be happy to do that.

Chairman **Leland**. Can I tell you that I think that you really ought to, because the problem is a long-term problem and we are just now beginning to develop processes by which we will pursue the campaign against AIDS. It might be very helpful if you would spearhead an effort like that, getting together with your colleagues in the other PVO's to try to get something done. I can't commend Interaction enough for the incredible job that it has done in coordinating the efforts of PVO's.

As you know, Interaction is a collection of PVO's that saw themselves, in some places duplicating efforts in the relief effort in Africa, and in other areas providing too little assistance. When Interaction was formed, it served to coordinate the activities of many PVO's. I must say that A.I.D. was aided to some extent, too, because it could go to one central organization to find those people who were doing certain things in certain areas. It provided a much more efficient way of rendering appropriate relief aid.

Mr. **Gerber**. If I might respond, Mr. Chairman, all of the agencies that I have mentioned, including ours, are members of Interaction, and perhaps we might push Interaction to organize an AIDS committee or subcommittee within their structure to play the organizational function for getting those agencies specifically interested and concerned with AIDS to link into the relevant areas within A.I.D. and maybe start some serious dialog in terms of long-term goals, long-term funding possibilities, long-term programmatic interests, to make sure that we might be channeling our efforts to areas where we can play an important role rather than a duplicating effort of things that are going on within universities, WHO, or other private organizations that are not PVO's.

Chairman **Leland**. I think that that would be an invaluable resource. I think that is a great suggestion, and I would hope that you would pursue that. I certainly will do what I can, and get my colleagues to bring together the PVO's and A.I.D. to develop some formal relationship there.

Let me ask you, in a somewhat related matter, A.I.D. officials have stated that there were no PVO's represented at the recent International AIDS Conference in Stockholm, possibly indicating a low level of interest by PVO's in participating in AIDS activities. Do you feel that this is an accurate assessment?

Mr. **Gerber**. No, I disagree 100 percent. I would say it is a low level of available funds to go off to Sweden and spend some time there on the part of the PVO's. Basically we are talking about budgetary restrictions, and I think we as PVO's need to measure the payback from attendance at this 3-day type of international conference versus allocating the funds elsewhere.

Chairman **Leland**. You have read some of the results from the conference, I am sure.

Mr. **Gerber**. We have, yes.

Chairman **Leland**. Do you think that it might have been more valuable for you to have attended and participated actively?

Mr. **Gerber**. If we could have afforded it, probably yes. I mean, we would very much liked to have gone. As I said, it was a budgetary issue. We have, and a number of others I can mention by name, those that I saw—CARE, for example, and Save the Children, as well as AMREF—attended the major WHO meeting, I think it was in—I lose track of time—it might have been November of last year or early February of this year, at which A.I.D. was present as well as all of the donor agencies were present, and a number of us have official relationships with WHO and are invited to the major meetings which bring together donors as well as NGO's.

Chairman **Leland**. Were you invited to the international meeting?

Mr. **Gerber**. Yes, we were.

Chairman **Leland**. You were?

Mr. **Gerber**. We were.

Chairman **Leland**. So A.I.D. did take the first steps. Do you feel, though, that A.I.D. might have invited and possibly given you grants to at least a representative number of you? That might have been very helpful.

Mr. **Gerber**. We would welcome that very much. [Laughter.]

Chairman **Leland**. Well, maybe through Interaction, you can develop that kind of facility to do so. I understand the financial constraints that PVO's face. Believe me, I understand, and my heart goes out to you.

Your statement was very definitive. You have answered all of my questions. I am sure that there will be other questions, and you know the drill. We will send you questions in writing, as we will all of the other participants today, if in fact we find that we haven't had all of our questions answered. We will keep the record open for the purpose of entering your responses into the record.

Mr. **Gerber**. Thank you. We will be happy to respond.

Chairman **Leland**. You have been very helpful one more time, and I really appreciate it.

Mr. **Gerber**. Thank you.

Chairman **Leland**. Dr. Chin, can I prevail upon you just one more time?

You heard me ask the question about the "zapping" of the AIDS virus from the blood supplies. Are you familiar with what is being done there?

Dr. **Chin**. No, I am not familiar, but let me just say that my perspective in terms of the kinds of technology that can be brought to bear, especially for assuring safe blood, the qualities that would be required would be that, No. 1, that it works. I think that we look with interest as to any development in the biomedical field, but then the other is then the cost-benefit, because I think with present technology we can make blood as safe as we can, but it is not 100 percent.

Now if there is a technology that will sort of close that gap, you are then talking about perhaps saving—at least in this country—a few hundred or thereabouts. I am not saying that that shouldn't be strived for, but at a certain point there is a cost-benefit, and I think politically it is dynamite to say that you are not going to spend, say, $100 million to reduce that extra 100, but it is in that ball park. At the present time, I think that with present tests and present technology we can eliminate maybe well over 99 percent of the problem. It is the remaining perhaps 1 percent or less that perhaps biomedical research can bring us the technology that would make it safe, but that I think is in the future.

Chairman **Leland**. Well, we waste a lot of money in this country on things like the MX missile and B-1B bomber, Dr. Chin. I would argue that if we were to save 1 percent of AIDS victims or the potential AIDS victims by putting that money into technology, or one-tenth of 1 percent certainly we ought to do it. A life is a life. It is something that we can only preserve to the extent that we are careful. We can't create it. Anyway, I think that there is never enough money that we can spend on helping to save humanity.

Let me ask you another question. We have talked a lot about Africa today. Where else in the world is the problem as extensive as it is in Africa, or at least comparable in scope?

Dr. **Chin**. We have information, as Mr. Langmaid said, that in certain parts of Latin America, especially in the Caribbean, we do have a problem sort of on the same general magnitude in terms of relative proportions as in certain cities in Central Africa, but I would say again——

Chairman **Leland**. Certainly Haiti——

Dr. **Chin**. Haiti and others.

Chairman **Leland**. The Dominican Republic, I presume?

Dr. **Chin**. Yes, but again we are still talking, even in Latin America, primarily about an urban phenomenon. We are seeing a shift and very disturbing shift of what initially was predominantly what we called a "Pattern 1," which involves primarily homosexual men and IV drug users in Latin America. Over the last several years there has been an increasing shift toward heterosexual transmission, so that in some of these areas, in Haiti and some other countries of the Caribbean, we are now seeing predominantly what we call now a "Pattern 2," where heterosexual transmission dominates. In terms of the potential for extensive spread, then, that is very disturbing.

Chairman **Leland**. And what about near our borders here in this country, in Mexico? You talked about Latin America. Mexico City, for instance, is very much overpopulated.

Dr. **Chin**. Again, the data we have from Mexico is that it is primarily an urban phenomenon, sort of mostly from Mexico City. They have done other studies. The Pan American Health Organization here in Washington is the one coordinating that. That is one of the regional offices of WHO, and they are responding to the problem in the Americas, obviously with coordination with the global program in Geneva.

Chairman **Leland**. Thank you. You corrected me on my statement, my misstatement about Zaire. Let me apologize.

Dr. **Chin**. No, I don't think—I didn't—what you saw may have been a nonresponse, say, to the prostitute problem, but I would say that that shouldn't be interpreted as the Zaire program not being either effective or exerting sort of leadership in that part of the world, because I think the whole prostitute situation is a difficult situation worldwide. I would say even in New York City I don't think they have solved that problem yet.

Chairman **Leland**. That's for sure. All I wanted to do is to apologize to Zaire, if in fact I was incorrect. I was speaking based on something that had been told me, possibly by someone who was not expert in the area, and I certainly don't want to exacerbate the problem of Zaire's image at this point in this hearing. I am glad that you would suggest, as the expert, that Zaire is up front in dealing with the problem of AIDS.

Thank you very much, Dr. Chin. I want to thank everybody for your attendance here today and your participation, those panelists who are still left here. This has been, I think, one of the most outstanding hearings that we have had with the Select Committee on Hunger. We hope that we can do our part in the campaign against this horrible disease. We have shown the interrelationships between AIDS and the problems of hunger and malnutrition in the Third World, the threat to child survival programs and the possible impact on other ongoing programs, so I am very happy that we had this hearing.

This hearing will not go unnoticed. The Congress will know very much about what we have discovered here today, and we will pursue with fervor and interest efforts to slow the spread and lessen the impact of AIDS in the Third World.

Thank you very much. This committee hearing is adjourned.
[Whereupon, at 1:15 p.m., the committee adjourned.]
[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF AMBASSADOR WANUME KIBEDI, PERMANENT REPRESENTATIVE OF UGANDA TO THE UNITED NATIONS

UGANDA AND THE FIGHT AGAINST AIDS

When the first cases of AIDS (Acquired Immuno-deficiency Syndrome) were first reported from the USA around the beginning of this decade, one would have been forgiven for assuming that modern science would in little time find a cure for this terrible disease, and that the problem would soon go away. The fact that those early cases appeared to be confined to homosexuals and intravenous drug abusers also helped to promote a widespread but false sense of security, with many people feeling that the matter was for "them" and not "us".

As we approach the end of the decade, the AIDS outbreak has assumed pandemic proportions in the world, affecting both men and women, and neither a cure nor a vaccine is in sight.

The seriousness with which the AIDS problem is now perceived is exemplified by the fact that last year, for the first time, the issue was taken up by the United Nations General Assembly, which passed Resolution 42/8 on the prevention and control of AIDS. The Resolution recognized the role played by the World Health

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Organization (WHO) in the fight against AIDS; commended Governments which had set up AIDS Control Programmes and urged other Governments to do likewise; requested the U.N. Secretary-General, in co-operation with the Director-General of WHO, to co-ordinate the response of the United Nations system to the AIDS pandemic; and also requested the WHO Director-General to report to the General Assembly at its next Session on "new developments in the global AIDS pandemic".

The Director-General has now prepared his report, entitled "Global Strategy for the Prevention and Control of AIDS", and the U.N. Secretary-General will submit it to the 43rd Session of the General Assembly as Document A/43/341. The report makes sombre yet compelling reading. Paragraphs 37 and 38 state:

> "37. From the available data, WHO estimates that, during 1988, approximately 150,000 new cases of AIDS will occur. Therefore, the number of new AIDS cases during 1988 will equal the total number of cases that have thus far occurred worldwide. Adopting the conservative estimate that 5 million people are currently infected, a cumulative total of 1 million AIDS cases would be expected by 1991. The period 1988-1991 would therefore witness over 5 times more AIDS than have thus far occurred.
>
> "38. HIV infection is lifelong. The virus can survive in the human population if, during the lifetime of an infected person, it can spread to one other person. This suggests that, unless a curative treatment or a preventive vaccine is developed, HIV infection will perpetuate itself relatively

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> easily. Neither cure nor vaccine are likely in the next several years. Despite considerable research a vaccine may be further away than was predicted a year ago."

On coming to power in January 1986, the National Resistance Movement (NRM) Government in Uganda soon recognized the dangers paused to the general public by AIDS, a new disease whose full dimensions were a mystery. The Government, in line with its general policy of openness and frankness in matters of public interest and concern, adopted a two-pronged approach to the AIDS outbreak:

1. Informing and educating the general public about the dangers of the disease and on the measures that had to be taken to prevent its spread.
2. Seeking the assistance of other countries and external agencies, WHO in particular, in the prevention and control of the disease.

The control of the AIDS epidemic was considered by the Government to be a matter of the greatest priority. In October 1986 the Ministry of Health set up a National Committee for the Prevention of AIDS, under an experienced medical doctor as Director. The Committee is comprised of a wide cross section of members from several Government Ministries and from the private sector, including the main religious organisations.

In January 1987 a team from WHO visited Uganda and assisted in the preparation of a short-term national AIDS control programme. WHO staff also subsequently assisted in the preparation of a comprehensive medium term plan.

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In conjunction with WHO the Ministry of Health organized a Donors Conference in Kampala in May 1987 in support of the AIDS control programme. The Conference, the first of its type in Africa, was a resounding success, considerable financial and material pledges being made by several donor countries and agencies. Similar such national donor meetings, organized jointly with WHO, were subsequently held in eleven other African countries.

Uganda has in place a 5-year AIDS Control Programme (1987-1991) which has seven major components namely:

(i) education and information
(ii) blood screening
(iii) protection of the general public through the supply of syringes and condoms
(iv) a national surveillance system to monitor the extent of the disease
(v) procurement of drugs for the treatment of AIDS cases
(vi) operational research into all aspects of the disease
(vii) training of health workers

Philip J. Hilts, writing in the Washington Post Weekly Journal of Medicine "Health" of May 24, 1988 had this to say about the Uganda AIDS Control Programme:

> "One of the most advanced AIDS prevention programs in the world, more advanced than the U.S. national program, is the W.H.O.-sponsored program in Uganda. There, a random national survey to find out who is infected is nearly complete, and frank texts are beginning to be put into schools."

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The strategy of openness and frankness adopted by the Uganda Government in confronting the AIDS problem was not accidental. It was a deliberate matter of policy decided upon by the Government following recognition of the fact that no cure or vaccine existed to deal with the disease, and that the best strategy was prevention. But one could not achieve prevention where a national problem was shrouded in secrecy or in pointless and self-defeating denial of its existence.

Unfortunately some outside journalistic interests exploited this policy of openness, making trips to Uganda for the purpose of writing sensational stories about the AIDS outbreak. Trips to Rakai, the District where the first AIDS cases were reported in Uganda, and to Mulago Hospital, where a number of AIDS patients were being treated, became a sort of journalistic pilgrimage for representatives of the international media. More often than not there was little attempt at objectivity or balance: the watchword was drama, or sensation. The overall result was a caricature of the state of affairs in Uganda, no more accurate than a description of any particular city or country based on scenes taken from the local brothel or lunatic asylum.

The world was given the impression that Uganda was awash with AIDS, a suggestion which is simply not true. There is no doubt that there is an AIDS outbreak in the Country but the extent of the problem has been greatly exaggerated, and Government is doing everything possible to contain it.

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Renée Sabatier, writing in the PANOS publication entitled "BLAMING OTHERS - Prejudice, Race and Worldwide AIDS", had this to say about the international media attention to Uganda resulting from the Government's openness policy:

> " The policy meant that during 1986-87 reporters flocked to the country to capture the story of AIDS in print and on film. Overworked health ministry officials gave hundreds of interviews and briefings; staff at medical centres answered the same questions again and again; patients in hospitals found their personal details turning up in international newspapers; prostitutes and truck drivers became overnight authorities on the sexual habits of the nation; a foreign film crew, desperate for footage of AIDS victims, burst without permission into a mission hospital outside Kampala and began filming the patients without permission. So many international stories appeared about Uganda's "slim disease" that the authorities began to wonder whether Uganda could ever be mentioned without conjuring up the image of a country devastated by AIDS."

Not only Uganda, but Africa as a whole has been the subject of tendentious reporting on the subject of AIDS. Here is what Hilts says in the Washington Post article mentioned above:

> "The tale of AIDS in Africa is not one of widespread devastation and the collapse of nations. There are 50 countries in Africa, and AIDS exists substantially in only a few of them in the centre of the continent."

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> "Even in those countries, the disease is intensely concentrated only in some urban areas and the roads between them. The rural areas are largely free of AIDS."
>
> "Going by the number of those who have died, AIDS is not among the top five diseases. In most places, it is not among the top 10. In many African countries, in fact, the disease seems nearly nonexistent."

Despite the mispresentation of the state of affairs in Uganda so far as this matter is concerned, Government is determined to pursue a vigorous and enlightened policy in the fight against AIDS, based on educating the general public, particularly the young people, who are the most vulnerable group. The consolation for the Government, and for the people of Uganda, is that responsible international agencies, and also many governments in the world recognize the positive effects of the policies applied by the Uganda Government in the fight against AIDS, and have as a result rallied to our assistance. Commenting on Uganda's campaign in the fight against AIDS, a 1988 UNICEF publication entitled "Proposals for Supplementary Funding - Projects for Children in Developing Countries" has this to say:

> "A particularly important campaign will operate throughout the country's 6,700 primary and 200 secondary schools to reach school children before their sexual habits are formed. A feasibility study has already indicated broad parental acceptance of AIDS education in the schools. Five teams of five trainers will travel throughout the country giving courses to primary and secondary school teachers in the use of new teaching materials

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developed by the Ministry of Health and UNICEF, reaching 14,400 teachers over a period of three years. After the first eighteen months every school should have at least one trained teacher, and eventually at least two.

The Government of Uganda has committed almost 10 per cent of the national budget for AIDS programmes, but as that money was in local currency it has been difficult to purchase equipment and supplies from abroad. Supplementary funds are therefore needed to provide materials, training and transport for all project sites, and to provide additional allowances for low-paid Government health workers to enable them to devote their full energies to the project."

I would now like to outline the latest position concerning the fight against AIDS in Uganda. This is based on information provided me within the last few days by Dr. S. I. Okware, Director of the AIDS Control Programme in Uganda:

1. Management of the AIDS Control Programme: This has been greatly strengthened. In 1986 the Programme had 2 members of staff. Today it has over 40. They deal with epidemiology (the study of the incidence and spread of the disease), blood transfusion and laboratory work. WHO has seconded 3 members of staff to the Programmme. District health workers have been trained and posted upcountry. 10 motorcycles have been acquired exclusively for the Programme, and 30 more are on order.

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2. Surveillance: Indications are that cases are doubling every six months. The increase has risen from 17 cases in 1983 and 29 in 1984 to 2,700 by December 1987. National serosurveys have been completed over most parts of the country (Buganda, Western and West Nile regions), and funds are urgently required to conduct the survey in the remaining areas. Evidence indicates that 85 per cent of the AIDS cases are aged 20 - 40; 10 per cent between 0-1 year; and there is virtually no infection for the 5-14 year category. The last age group constitutes over 50 per cent of the population, and therefore a large part of the population can be protected once the AIDS prevention message gets across.

3. Health education: Great emphasis has been placed on this aspect of the fight against AIDS. The Health Education Division has been restructured and strengthened at the centre and at the District level. District Health Educators have been recruited. The transport section has been revitalised, and 10 generators imported. About 4 million leaflets, posters, and bumper stickers have been printed, up from a mere 2,000 in 1986. Seminars for district officers, health officers, Church leaders, members of the National Resistance Army and others are held on a regular basis. Over 200,000 volunteers have been recruited to assist in health education at the

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village level. Over 2,000 teachers have already been trained in a comprehensive school health programme, and the exercise continues. There is active collaboration between the ACP and Non-Governmental Organizations regarding health education measures.

4. Blood Screening: Right now there are 13 blood screening centres in the country, and another 16 are projected to be operational within the next 2 months, making a total of 29 such centres. Blood testing equipment which can be used upcountry where there are no cooling facilities due to lack of electricity has been ordered from the USA. Each blood-screening centre costs $25,000 to instal and operate, and therefore a total of some $800,000 will be needed within the Medium Term Plan to make all the centres functional. The EEC has promised $2.2 million for the rehabilitation of Nakasero Blood Centre but the donation has not yet been received. It is hoped that tenders for rehabilitation work of the Centre will be opened in July.

5. Uganda Virus Research Institute: This has now been appointed a reference centre for virus research, and $400,000 has been made available from the U.K. Plans are underway to transform the centre into a high level research institute.

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6. Supplies: 18 tons of medical supplies were received from the EEC last July, but unfortunately not much has been forthcoming since then. Medical supplies are needed urgently to assist in the rehabilitation of medical services and for patient care.

7. Finances: Important financial pledges were made at the Donors Conference which was held in Kampala in May 1987. $3.2 million out of $4.2 million pledged has now been received, including $500,000 from the USA, $800,000 from Sweden, $314,000 from the U.K. Pledges of $0.9 million from Italy and $400,000 from DANIDA are awaited. Additional funding promised by UNICEF ($2 million), the EEC ($2.2 million) and UNDP ($400,000) is still awaited. The AIDS Control Programme is most grateful for extra funding of $250,000 and 1.7 million Shillings in local currency contributed by the USA outside the Conference pledges.

The Programme has experienced a problem in that the purchasing power of the dollar has dropped considerably over the past year as a result of the fall in the value of the dollar against European currencies, in which the bulk of supplies are purchased. Inflational trends within Uganda have also tended to increase the cost of local materials and services.

The Programme is now in the middle of its Medium Term Plan (January - December 1988) which is budgeted at

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$4.5 million. The Short Term Plan ended on 31st December 1987.

The AIDS Control Programme greatly appreciates the assistance it has so far received from outside countries and agencies, and intends to redouble its efforts in the fight against AIDS. The Programme, however, appeals for further financial and material assistance to enable it to continue in its task.

In making this appeal on behalf of the AIDS Control Programme I wish to point out that Uganda continues to experience considerable difficulties as a result of the social upheavals brought about by the ravages of past regimes, in the course of which much of the infrastructure was destroyed. The task is not made any easier by the existence of endemic diseases such as tuberculosis, tetanus, malaria, diarrhoea, and health problems resulting from malnutrition and anaemia, which in fact are far greater killers than AIDS. The medical problems of the country are made even more difficult by the shortage of trained medical staff. Uganda has one doctor for every 40,000 people, and thus one can easily see the pressure under which the medical services have to operate.

The fight against AIDS is important not only to alleviate the suffering of the individuals and families immediately

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affected, but because it has serious implications for the economic development of the Country as a whole. In this respect three factors are important in so far as Uganda, and indeed Africa as a whole, are concerned:

1. The disease mostly affects people in the age category of 15 to 55 years, under which some 90 per cent of the cases fall. For much of the developing world this is the most productive part of the population, on whom vast resources would have been expended by the country in terms of their education and other social services. That category also provides the bulk of human resources for the professions, the business sector, as well as the armed forces. It is therefore easy to see that the more the AIDS problem spreads within this age category, the greater the burden will be on the public services the country provides, and the adverse effect on national economic activities.

2. The evidence shows that in Uganda and elsewhere in Africa AIDS affects men and women almost equally. It is spread largely by sexual contact between men and women, rather than between men and men or through intravenous drug abuse as it does in other parts of the world. The position therefore is that with an uncontrolled outbreak, large numbers of women are liable to be affected, unlike the position appertaining elsewhere. Uganda is basically an agricultural country, and women

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are an important factor in agricultural production. At the moment 85 per cent of the country's foreign export earnings is based on coffee. This crop, like many other crops which are utilised in the export trade, is grown on small plantations in individual homesteads rather than on large commercial plantations as in other parts of the world. It is therefore clear that taking large numbers of women out of agricultural production, either through illness or death, is liable to have a direct bearing on the country's ability to grow food and other crops.

There is also the fact that pregnant women who have the AIDS virus are liable to pass it on to their newborn babies before or during birth - perinatal transmission. The chances of this happening are estimated by WHO to be 50 per cent. This is largely the method by which the 0-1 year age category, which makes up 10 per cent of all AIDS cases in Uganda, would have acquired the disease. The women who are infected with the AIDS virus are therefore liable to add to the medical and social problems of the country, in that not only themselves but the children who may in turn be infected will require attention by the medical and social sevices.

3. The problem as a whole involves the Country in having to divert enormous resources, both in terms of manpower and money, to deal with all aspects of the disease including preventive measures. The concern here is that we are still in the early stages of a serious outbreak, and therefore as time goes on more and

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more resouces will be required to deal with the problem. The greater the resources specifically diverted to the fight against AIDS, the more the country will be deprived of precious manpower and funds which could have been applied to developmental projects in other sectors of the economy. Even at the best of times funds for development are in great scarcity, given the economic problems that beset much of the Third World. The AIDS nightmare is hence nothing less than an unwelcome additional load on an already overburdened national Treasury.

There is, therefore, a direct correlation between AIDS and an adverse effect on development. Although it is early days yet, it can be said that the fight against AIDS has already made important gains in Uganda, in that people are now more aware of the hazards of the disease, and are therefore taking greater care of themselves. But so long as there is no cure or vaccine against AIDS, all aspects of the battle against the disease will have to be on a continuing basis. There cannot be a let up in the education and public information campaign, or else people may slip back into their old habits thinking that the worst of the problem had passed.

It is for this reason that I would wish to emphasise the importance and urgency of continuing with material, financial and technical support for the AIDS Control Programme in Uganda. We cannot afford to let our guard down in this area.

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There has been much debate as to the origin of AIDS, and there was a tendency by some writers to blame Africa for the outbreak. The Panos Institute, in their publication entitled "AIDS and the Third World", has this to say on this subject:

> " The short history of the AIDS epidemic has been one in which everyone blames someone else for starting the epidemic. American news media have pointed the finger at Africans, Haitians and homosexuals; some Europeans, the Japanese and other Asians have blamed the Americans; and Africans have accused Europeans. Each group or country has sought to portray itself as the innocent victim of a disease brought by outsiders with inferior moral standards, as if the apportioning of blame would somehow turn back the clock to the days before AIDS existed."
>
> " In fact very little is known about the origins of the AIDS virus, and even less about the way in which early carriers of the virus unwittingly spread it within and between countries."
>
> " What is most important is not where the AIDS epidemic came from, but where it is going."

Some writers came up with theories which were completely unfounded, and which had the effect of spreading prejudice and bias against Africans. In 1986 two Harvard Univeristy scientists came out with a theory which suggested that the AIDS virus had spread to man from African green monkeys, and they based their proposition on results from laboratory tests they had been conducting over a period. Early this year the two scientists

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announced that the blood samples on which they had worked had been contaminated in the course of their researches, and they withdrew the proposition that AIDS had spread from African green monkeys. As Renée Sabatier says in "BLAMING OTHERS" "it is to their credit that they openly acknowledged this" but by the time the acknowledgement came the false news had spread all over the world. Moreover the correction of the error has not received anything like the publicity generated by the erroneous theory when it was first propounded.

Blaming other people for the outbreak of AIDS, or exaggerating the extent of the problem, makes no contribution to the important task of containing the disease or of seeking an appropriate cure or vaccine. Such stories or arguments are diversionary.

What is important and critical is for adequate resources and determined efforts to be applied to the task of preventing and controlling the spread of AIDS in the world, and I hope that this august Committee will be able to make recommendations which can contribute to this task in a practical and meaningful way. That is the message, and the appeal, which I wish to leave with the Committee.

I thank you.

PREPARED STATEMENT OF BRADSHAW LANGMAID, DEPUTY ASSISTANT ADMINISTRATOR, BUREAU FOR SCIENCE AND TECHNOLOGY, U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT (U.S. A.I.D.)

Thank you, Mr. Chairman, for inviting A.I.D. to testify on this important subject. If not brought under control, HIV, the Human Immunodeficiency Virus, can have a critical impact on the development prospects of many poor countries.

The Agency has just completed a semi-annual report on its AIDS policy and program. To facilitate the Committee's consideration of these issues, I have attached a copy of this report to my statement.

Very briefly, I would like to summarize it:

The report surveys the extent of the AIDS epidemic in developing countries and its potential impact on development. The World Health Organization estimates that there have been over 92,000 cases of AIDS worldwide and more than 5 million people infected.

The World Health Organization Global Programme on AIDS (WHO/GPA) is the cornerstone of the U.S. assistance policy on AIDS. The U.S. continues to be the largest contributor to WHO/GPA with a $15 million donation during FY 1988. As well as budgetary support, A.I.D. provides condoms ($3 million in FY 1987), technical expertise, and day-to-day interaction and coordination of efforts.

The report then focuses on the A.I.D. AIDS prevention and control program.

o In FY 1988, Congress earmarked $15 million for A.I.D.-managed bilateral AIDS-related assistance efforts. Of this amount, $6.4 million will be used for programs in the African Region; $3.9 million will be used for programs in the Latin American and the Caribbean Region; $1.3 million will be used for programs in the Asian and Near Eastern Region; $3 million for condom procurement; and the balance, $0.4 million, for monitoring the epidemic.

o A.I.D. is supporting a number of AIDS-specific projects including: 1) AIDSCOM (public health communications for HIV/AIDS prevention); 2) AIDSTECH (technical support for blood screening, surveillance and epidemiology; 3) the HIV and AIDS Prevention in Africa project managed by A.I.D.'s Bureau for Africa; 4) condom distribution; 5) A.I.D. Regional Bureau and mission activities; 6) collaboration with CDC and NIH; 7) an AIDS data base and modeling effort at the U.S. Bureau of the Census; and, 8) collaboration with PVO's.

o In addition, a number of AIDS intervention activities are being built into ongoing A.I.D. health, population, and nutrition projects such as: ensuring the use of sterile skin-piercing instruments; training of health workers in other programs and providing them with basic equipment to protect them from infection; and expanding data collection in AIDS-related areas.

o A.I.D. coordinates the U.S. efforts in developing countries by chairing a subcommittee on this topic under the Federal Coordinating Committee on AIDS. A.I.D also participates in the Interagency Working Group on AIDS Modeling and Methods which is chaired by the State Department.

Mr. Chairman, you specifically expressed the concern that A.I.D. programs such as "Child Survival" might be threatened by the spread of AIDS. There is increasing evidence that immunization programs do not risk transmission of AIDS, and that an HIV infected child will not be adversely affected by being immunized. However, if an HIV infected mother dies, her surviving children will lack care. If she becomes pregnant while infected with HIV, her child, in about one-third to one-half of all such cases, will be born with HIV and will likely die before reaching two years of age.

On a programming level, we have not reallocated funding from child survival to the AIDS prevention program. Where the Agency supports child survival, maternal health and family planning programs, we have requested that these programs take into account the threat of HIV infection and incorporate appropriate preventive measures in their training and service components. For example, special efforts are made to:

o Ensure the use of sterile skin-piercing instruments and to train health workers in other programs and provide them with basic equipment to protect them from infection. A.I.D. is working closely with WHO and UNICEF to provide the needed supplies and training to ensure that immunizations are given only with sterile needles and syringes.

o Our family planning programs provide opportunities to communicate important AIDS prevention messages. Our Office of Population has supported a variety of AIDS activities through its ongoing projects. These have included operations research to assess the interaction of family planning and AIDS prevention activities, numerous training and educational activities, and the provision of condoms to 37 countries thus far.

Regarding the broad impact of this epidemic upon economic development, it is still too early to make reliable predictions. We do share your concern, however, that as this disease strikes the most productive age groups in society, and frequently the more educated and trained within these age groups, it can have an adverse impact on production. At the same time, if the infection can be prevented from spreading through rural areas, it may not seriously affect food production. At present, the pace of the spread of infection in rural areas seems to be much slower than in urban areas.

Finally, Mr. Chairman, let me emphasize that we know how grim this epidemic has been and continues to be. An extraordinary worldwide effort under WHO direction has been mounted to address the many facets of this epidemic. The U.S. has been and will continue to be a leader and major supporter of the WHO/GPA program. To date, 143 countries have requested WHO/GPA assistance, and 121 have received it. This assistance has resulted in the formulation of short-term AIDS prevention and control plans by 58 countries and medium-term plans by 25 countries.

There is evidence that AIDS awareness is increasing in the general populations of some countries, such as Rwanda and Uganda. There is also evidence, from Kenya, that groups with high risk behaviors can change these behaviors. Zimbabwe, Zambia and Ecuador are improving the safety of their blood supplies for all, and virtually every capital city throughout the world now has at least one HIV-free site for blood transfusions. These are hopeful signs which need to be built upon rapidly if there is to be progress in halting the spread of AIDS.

We would be pleased to answer any questions. Thank you.

Attachment: "The Efforts of the Agency for International Development to Combat the Spread of the Aids Epidemic," Report to the Committee on Appropriations, U.S. Senate, May, 1988.

The Efforts of the
Agency for International Development
to Combat the Spread of the AIDS Epidemic

Report to the
Committee on Appropriations
U.S. Senate
May 1988

As of May 10, 1988, the World Health Organization (WHO) estimates there have been over 91,905 cases of acquired immune deficiency syndrome (AIDS) worldwide. More than 5 million people may presently be infected with the human immunodeficiency virus (HIV).

If nothing is done to control the epidemic, WHO predicts that the number of infected persons may increase up to ten-fold within the next 5 years. At present, the probability that HIV-infected people will subsequently develop AIDS appears to be 25 to 50 percent, but this figure grows from month to month. With no cure or vaccine in sight, the situation for many developing countries is grim.

THE AIDS PANDEMIC

AFRICA: In Africa, particularly Central Africa, infection appears to have spread widely, primarily through heterosexual contact. In at least eight capitals -- Bangui, Brazzaville, Bujumbura, Dar es Salaam, Kampala, Kigali, Kinshasa, and Lusaka -- data from samples of urban adults indicate that over 5 percent of these populations have been infected with HIV. Most governments have formed national AIDS committees and are preparing national plans for AIDS prevention and control.

LATIN AMERICA AND THE CARIBBEAN: In the Caribbean, infection has also spread widely, initially through homosexual contact, more recently through heterosexual contact. In Port-au-Prince, Haiti, like much of urban Central Africa, over 5 percent of urban adults are infected with the virus. In most of South America, infection is still largely confined to homosexual and bisexual males and intravenous drug users, with less than 1 percent of the adult population infected. Even so, there is potential for increased spread of infection. As governments have become aware of the AIDS pandemic in both the Caribbean and Latin America, national AIDS committees have been formed and national plans prepared.

ASIA AND THE NEAR EAST: In Asia, the epidemic appears to be at an earlier stage, but recent reports indicate that infection is now spreading among high-risk populations such as intravenous drug users. In May 1988 the Ministry of Health in Thailand announced that the number of drug addicts testing positive for HIV had risen to 16%. However, the level of infection among the general population remains quite low. In general, Asian governments view AIDS as a less urgent problem and have moved more slowly to undertake substantive AIDS prevention and control efforts. The government of the Philippines is a notable exception, having sought our support in beginning an extensive education campaign.

THE THREAT TO INTERNATIONAL DEVELOPMENT

Although the world scientific community cannot describe with precision the scope of the current epidemic nor its potential growth in the coming years, it is clear that the impact of the AIDS pandemic extends to all sectors of development.

NATIONAL ECONOMIES: Through sexual transmission routes, HIV principally attacks young adults, who are among the most productive members of society. Much of the data on HIV infection rates in the developing world comes from urban centers. It appears that HIV is infecting growing numbers of urban young adults, who are often the best-educated members of society. Although there is limited information on the extent of HIV infection in rural areas, it is likely that the disease is spreading into these agricultural areas as well. Economic output is likely to decrease as increasing numbers of productive urban and rural workers become sick and die with AIDS and AIDS-related complex (ARC).

HEALTH STATUS AND CHILD SURVIVAL: This spread of HIV among adults will lower the health status in these nations and also threaten the survival of children. The AIDS epidemic endangers children directly, through HIV transmission from mother to infant, and through blood transfusions for children with diseases like malaria. It also threatens children indirectly. A child with an infected parent is likely to lose that parent, and in time both parents, through this tragic disease. Studies from Central Africa tell us that as many as 1 in 5 urban children face this situation. Thus, the AIDS epidemic may well undermine the hard-won gains made in increasing health status and child survival in the developing world.

NATIONAL HEALTH BUDGETS: The health systems of developing countries are also imperiled by the spread of the AIDS pandemic. The cost of dealing with AIDS in many countries will take funds and personnel needed for other programs in health, family planning, and education. Scant health care resources will be further stretched by increasing numbers of AIDS and ARC patients. More and more frequently, we are hearing about general shortages of medicines, particularly anti-tuberculosis agents, because of demand for treatment of HIV-infected patients. This drain on health resources in turn is likely to impede economic development.

THE WORLDWIDE RESPONSE

This threat to health and development has been recognized by the world community. In February 1987, the World Health Organization undertook a worldwide effort to control the spread of HIV -- the World Health Organization Global Programme on AIDS (WHO/GPA).

In one year WHO/GPA has marshalled the support of almost every nation, raised funds, designed, and begun to implement a global AIDS strategy. This strategy requires that a strong AIDS program be developed in every country. Already, national AIDS committees have been developed in over 100 countries. Using WHO guidelines, over 50 countries have prepared written plans for national AIDS prevention and control. By the end of 1988, WHO/GPA expects to have AIDS medium-term plans underway in 125 countries.

Appendix Tables A and B provide summaries of WHO/GPA resources and country activities. Appendix Table A lists resources pledged to WHO/GPA for CY 1988. Donor pledges to date total $55 million, including carry-over of funds from CY 1987. The U.S. remains the single largest donor, with a $15 million FY 1988 commitment. Other major donors include Sweden, the United Kingdom, Switzerland, and Canada. In addition, France, Germany, Italy, and the EEC are carrying on extensive programs of bilateral assistance. Appendix Table B outlines the status of WHO/GPA program support to countries.

A.I.D. AND WORLD HEALTH ORGANIZATION COORDINATION

The United States fully and actively supports WHO/GPA. This support is a cornerstone of our assistance policy. In FY 1986, A.I.D. was the first donor to provide financial support to WHO/GPA with a donation of $1 million to WHO/GPA and $1 million to the WHO regional office in Africa. In FY 1987, A.I.D. made a $5 million contribution to WHO/GPA. The U.S. remains the largest contributor to WHO/GPA with a FY 1988 contribution of $15 million. U.S. support for WHO/GPA takes a variety of forms:

o We provide general budgetary support for the WHO/GPA worldwide program. In FY 1987, the U.S. $5 million contribution represented 20 percent of such general budgetary support. In FY 1988, the U.S. $15 million contribution is 23% of the planned $66 million program.

o We also provide funding for WHO/GPA country programs. In its 1988 program, WHO/GPA anticipates $26 million being spent on worldwide activities and $40 million being committed to country AIDS activities. In our $15 million contribution to WHO/GPA, we have reserved $5 million as a budgetary contribution for these country activities.

o A.I.D.'s bilateral program is designed to support WHO/GPA country programs. At the local level, the day-to-day interaction between mission staff and WHO/GPA officials is close and reinforcing. Many of our ongoing health and population activities work in areas directly affected by the AIDS epidemic and therein become an integral part of the AIDS control effort, although they may not get counted as part of our overall AIDS program.

o In FY 1987, we made $3 million in condoms available to WHO/GPA. The countries receiving this support were drawn from the WHO/GPA list of priorities, and the condoms were provided through the WHO resident representative.

o We have also provided extensive technical expertise to WHO/GPA. Members of our own A.I.D. staff have been seconded to WHO/GPA. Technical experts under our technical assistance contracts, AIDSCOM and AIDSTECH, are being made available on a long-term basis to WHO/GPA in specialized areas. Professional staff members of the AIDSCOM and AIDSTECH contracts work closely with WHO/GPA by providing direct technical support to WHO/GPA staff in the field, and by debriefing with WHO/GPA staff after virtually every A.I.D. field trip.

THE AIDS POLICY OF THE AGENCY FOR INTERNATIONAL DEVELOPMENT

The Administrator approved an Agency AIDS policy in April 1987. As stated above, a cornerstone of this policy is cooperation, coordination, and support of WHO/GPA. In addition to, and in coordination with, this multilateral response, the policy mandates development of bilateral programs to control the further spread of HIV, and to monitor the epidemic and its effect on development.

The key program components of the policy are:

-- prevention of HIV transmission in all U.S.A.I.D.-supported health, population, and nutrition programs;

-- surveillance to monitor the spread of HIV;

-- public education aimed at increasing the level of AIDS knowledge, decreasing fear and ignorance about AIDS, and promoting behavioral change;

-- prevention of HIV transmission occurring via blood transfusion;

-- condom procurement and distribution;

-- limited intervention-oriented and operations research aimed at improving program effectiveness and adapting programs to particular settings.

This policy is designed to be flexible and capable of response to changes in the course of the epidemic and advances in biomedical technology and knowledge. Most importantly, the policy is designed for rapid implementation of a program which will slow the further spread of AIDS.

FUNDING FOR FY 1987, FY 1988, AND FY 1989

In FY 1987, A.I.D. allocated approximately $17 million for global AIDS control: $5 million for WHO/GPA, and $12 million for A.I.D.-managed projects (See Table 1). Of the $12 million, $3 million was used by the Office of Population for meeting requests for worldwide condom distribution. The remaining $9 million provided technical assistance, and bilateral and regional prevention and control efforts in collaboration with WHO-coordinated host country programs. This included $3 million obligated by A.I.D.'s Bureau for Africa for regional AIDS activities in 14 African countries.

In FY 1988, Congress appropriated $30 million for AIDS prevention and control in developing countries (See Table 1). Of the $30 million, $15 million is earmarked for WHO/GPA and $15 million for A.I.D.-managed bilateral assistance efforts. Of the $15 million for bilateral assistance work through A.I.D., $6.4 million will be used for programs in the African Region, $3.9 million will be used for programs in the Latin American and the Caribbean Region, and $1.3 million will be used for programs in the Asian and the Near Eastern Region. The Office of Population has been provided with $3 million for condom procurement. The balance, $0.4 million, will be spent in activities involving monitoring the epidemic. (See Table 1.)

For FY 1989, as for FY 1988, we are requesting $30 million in AIDS funds: $15 million for multilateral assistance to WHO/GPA and $15 million for bilateral assistance activities. These funds will be spent on AIDS-specific activities, but we also expect funding for non-AIDS-specific activities from the Health and Population accounts, the Economic Support Fund, and the Development Fund for Africa.

In the developing world there are always dollar resource constraints, but frequently of equal importance are the human and managerial resource constraints. As the control and prevention of the spread of AIDS involve issues of particular social, political, and cultural specificity and sensitivity, these limitations become even more important. These realities dictate that we prioritize our efforts.

A number of priorities are taken into account in this. We are giving highest priority to those countries where the infection is widespread, or which are close to areas of extensive HIV infection, or which have high-risk groups with a high potential for the further spread of HIV. Countries with major urban populations or on major transportation routes between urban populations must be given particular attention. The prevalence of other sexually transmitted diseases is a useful proxy for level of sexual activity, and therefore for understanding where prevention and public education programs need to be concentrated. In addition, we are taking into consideration an array of governmental and multilateral assistance factors such as: the interest and absorptive capacity of each developing country's government; U.S.A.I.D. mission support and U.S. foreign policy interests; and the monies and services being contributed by other bilateral and multilateral donors.

THE A.I.D. AIDS PREVENTION AND CONTROL PROGRAM

The AIDS prevention and control program of A.I.D. can be divided into two areas: those activities which are aimed specifically at AIDS prevention and control; and, those activities which represent additions to our ongoing health, population, and nutrition programs.

The leadership of WHO/GPA is of critical importance in the worldwide effort to control AIDS. That is why A.I.D. policy gives such priority to support for WHO/GPA activities. At the same time, due to the urgency of the AIDS pandemic, worldwide donors cannot afford the time or the luxury of building new institutions to deal with the AIDS problem. The worldwide response, under the leadership of WHO/GPA, is thus being built on the strengths of all collaborators. These strengths are being combined into a coherent program which provides timely response to the needs of affected countries.

A.I.D. contributes a number of strengths and assets as a bilateral donor. A.I.D. field mission presence and established worldwide network of operating health and population programs is a major program implementation resource. Similarly, A.I.D. capacities in the area of technical assistance and training, again particularly in the areas of health, population and public health communications, are also important assets. Finally, of course, our worldwide system for procurement and distribution of condoms in the developing world is probably unique. For these reasons, it is important that our AIDS program have a major bilateral program component to ensure that these management, implementation, and program resources are available to the worldwide effort.

AIDS-SPECIFIC ASSISTANCE: A.I.D. is supporting a number of AIDS-specific activities including: 1) AIDSCOM; 2) AIDSTECH; 3) condom distribution; 4) A.I.D. Regional Bureau and mission activities; 5) collaboration with CDC and NIH; 6) an AIDS data base and modeling effort at the U.S. Bureau of the Census; and, 7) collaboration with PVO's.

During 1987 and 1988, A.I.D.'s Offices of Health, Education, and Population, in coordination with the three Regional Bureaus, have jointly developed a worldwide AIDS prevention and control assistance project, the AIDS Technical Support Project. This project has two major components, dubbed AIDSCOM and AIDSTECH.

1) AIDSCOM, the public health communications component, is being implemented by the Academy for Educational Development, which has offices in New York City and

Washington, D.C. Major subcontractors are Johns Hopkins University, the Annenberg School of Communications at the University of Pennsylvania, and the firm of Doremus, Porter, Novelli. Funded by a 5-year, $15.4 million contract, AIDSCOM will use lessons learned from social marketing and behavior analysis to help national AIDS committees develop effective models of public education, social mobilization, and counseling for AIDS prevention. Operations research will focus on questions such as: What risk behaviors are most susceptible to communication interventions? How can marketing approaches be used in both public and private sector programs? How can community mobilization be focused to support specific risk behavior reduction? How can short-term behavior change be sustained through counseling and support?

2) AIDSTECH, the biomedical component, is being executed by Family Health International, located in North Carolina. Authorized for five years and $28 million, AIDSTECH is providing technical assistance in epidemiological surveillance, blood transfusion screening, treatment of sexually transmitted diseases, and the logistics of condom distribution. In order to ensure that interventions are sustainable and cost-effective, a project health economist provides consultation on financing of AIDS health care and prevention. AIDSTECH is also responsible for AIDS prevention-related training and dissemination of technical information.

These contracts were awarded in September 1987. Since then, the AIDSCOM and AIDSTECH projects have provided short-term technical assistance to 23 countries. (See Table 2.) Countries which have received needs assessment visits and/or completed technical assistance are: 1) in Africa -- Burkina Faso, Burundi, Ghana, Ivory Coast, Kenya, Malawi, Nigeria, Rwanda, Senegal, Tanzania, Uganda, and Zaire; 2) in Asia and the Near East -- Indonesia, the Philippines, and Thailand; and 3) in Latin America and the Caribbean -- the Dominican Republic, the Eastern Caribbean, Ecuador, El Salvador, Guatemala, Haiti, Jamaica, and Mexico. In addition, AIDSCOM and AIDSTECH are now organizing long-term projects in many countries.

3) Condom distribution: Another major AIDS-specific activity is the provision of condoms for AIDS prevention. A.I.D. has an excellent condom procurement and distribution system as part of its family planning program. Rather than duplicate this system for AIDS, we have simply added extra funds. To date, through this system, we have shipped additional condoms for AIDS prevention to 21 countries. A large proportion of these have been shipped specifically at WHO/GPA request to meet urgent needs.

4) A.I.D. Regional Bureau and mission activities: Almost all of the technical assistance activities described above have been part of a Washington-managed worldwide support project, even though the activities are carried out in specific developing countries in conjunction with our country-to-country, or bilateral, assistance efforts. We have used this mechanism thus far because AIDS is new, our experience is small, and we needed to create a worldwide response capacity. It was essential that the benefits of experience be gained as rapidly as possible.

As our country missions build program capacity, we will rely more and more on that capacity. In fact, decentralization is already underway. Several of our missions have already begun their own AIDS-specific activities and added AIDS-related activities to ongoing projects. Many are also allocating local currencies to augment AIDSCOM or AIDSTECH activities. We expect this process to continue.

Another mechanism for such country-specific support is the HIV/AIDS Prevention in Africa (HAPA) Project, a three-year, $20.5 million grant program designed to expedite Africa Bureau support of African mission initiatives concerning the epidemic on a national and regional basis. The project will finance AIDS-related sub-project activities carried out by host country government entities, private voluntary organizations, or other private sector institutions. The HAPA project will provide rapid and flexible assistance to African field missions for needs which could not otherwise be met.

5) Collaboration with CDC and NIH: A.I.D. is working with the Centers for Disease Control and the National Institutes of Health. For example, plans are currently being developed for A.I.D. support of a CDC intervention research project in Zaire. In the same vein, a joint A.I.D. and National Institute of Allergy and Infectious Disease (NIAID) conference was held in January 1988 to address anthropological perspectives on AIDS in Africa and help establish research priorities for AIDS prevention.

6) Bureau of the Census: The U.S. Bureau of the Census has received funding from A.I.D. to establish an international HIV and AIDS database to track the incidence and prevalence of the disease. Surveys, publications, cabled reports, and other data sources are being used to create the database. Projection models are currently being developed and will be utilized to estimate the course of the epidemic in various countries. These will provide a valuable addendum to the World Health Organization AIDS surveillance efforts.

7) Collaboration with PVO's: Recognizing the rapid response capacity of private voluntary organizations (PVO's) and their unique ability to carry out projects in the important non-governmental sector, A.I.D. is seeking to stimulate and support PVO-led AIDS prevention and control activities. A.I.D. support will also be provided to PVO's working in developing countries through grants.

NON-AIDS-SPECIFIC ASSISTANCE: In addition, a number of AIDS intervention activities are being built into ongoing A.I.D. health, population, and nutrition projects such as: ensuring the use of sterile skin-piercing instruments; training of health workers in other programs and providing them with basic equipment to protect them from infection; and expanding data collection in AIDS-related areas.

Our immunization programs have been threatened by the pandemic. While more and more data indicate that needles and syringes for immunization are very unlikely to transmit HIV, the theoretical possibility remains. To eliminate this possibility, A.I.D. is working closely with WHO and UNICEF to provide the needed supplies and training to ensure that immunizations are given only with sterile needles and syringes.

Our family planning programs provide an excellent opportunity to communicate AIDS prevention messages at little extra cost. In recognition of this, our Office of Population has supported a variety of AIDS activities through its ongoing projects. These have included operations research to assess the interaction of family planning and AIDS prevention activities, and numerous training and educational activities.

COORDINATION OF U.S. GOVERNMENT INTERNATIONAL ACTIVITIES

Because the Agency for International Development is the principal foreign affairs agency concerned with development assistance, it is uniquely placed to facilitate the coordination of the Government's international AIDS efforts in developing countries. Congress has also recognized this uniqueness and has exhorted the Agency to carry out this role. Through the Federal Coordinating Committee (FCC) on Information, Education, and Risk Reduction, A.I.D. has taken the lead to coordinate informational activities. The members, including representatives of the Departments of State, Defense, and Health and Human Services, have collected data on all their international activities in a common format, presented their programs, and exchanged summaries of country-specific activities. This subcommittee of the FCC will continue to meet to ensure coordination.

In addition, A.I.D. is a participant in the Interagency Working Group on AIDS Modeling which was organized by the State Department in May 1988. As described above, A.I.D. is funding efforts to monitor the spread of AIDS and gauge the impact of the epidemic on development. The Interagency Working Group on AIDS Modeling will function to coordinate A.I.D. activities with those of CDC, NIH, the State Department, and other government agencies.

RESEARCH

AIDS research is much less the mandate of A.I.D. than it is the mandate of other U.S. agencies, such as the Department of Health and Human Services (HHS). Consequently, our research is limited and intervention-oriented, relevant to AIDS prevention and control programs and other health, population, and nutrition programs in developing countries.

A.I.D.'s intervention-oriented research can be divided into four areas: behavioral research, epidemiologic research, operations research, and development and field testing of new prevention technologies. Behavioral research projects include social and anthropological research, and behavioral assessments such as knowledge, attitudes, and practices (KAP) surveys. Major areas within epidemiologic research include surveillance and studies of modes of HIV transmission, as well as the development of projection and impact assessment models. Operations research is aimed at making programs work better and lowering costs. In development and field testing of new prevention technologies, we are careful to serve a catalytic role and not supplant or slow down private industry. Examples include a trial we are now conducting of five rapid, simple HIV antibody tests, and development and testing of a new non-reusable syringe.

CONCLUSION

A.I.D. views the AIDS pandemic as a major threat to development, and so we are working to both monitor the impact of the pandemic and to implement programs which will control the spread of HIV and blunt this impact. The centerpiece of our program is support of WHO/GPA in its international leadership role. We have also created our own prevention and control projects which will be coordinated through developing country national AIDS committees and WHO leadership. In addition, A.I.D. is coordinating the international efforts of addition, A.I.D. is coordinating the international efforts of other U.S. Government agencies. A.I.D. has acted rapidly, in the past year, to develop an effective AIDS policy and programs to implement it. In the coming year, we will maintain that pace.

We know how grim this epidemic has been and continues to be, however, in the past year there has been progress. To date, 143 countries have requested WHO/GPA assistance, and 121 have received it. This assistance has resulted in the formulation of short-term AIDS prevention and control plans by 58 countries and medium-term plans by 25 countries. There is evidence that AIDS awareness is increasing in the general populations of some countries, such as Rwanda. There is also evidence, from Kenya, that groups with high risk behaviors can change these behaviors. Countries, such as Zimbabwe and Ecuador, have achieved safe blood supplies for all, and virtually every capital city, throughout the world, has at least one HIV-free site. These are hopeful signs which need to be built upon rapidly if there is to be progress in halting the spread of AIDS.

TABLE 1: A FUNCTIONAL BREAKDOWN OF THE A.I.D. AIDS BUDGET (in millions)

	FY 1987	FY 1988
WHO/GPA	5.0	15.0
A.I.D.	11.9	15.0
Condoms	3.0	3.0
Modeling *	0.2	0.4
Africa TA	6.2	6.4
ANE TA	0.6	1.3
LAC TA	1.9	3.9

* Activities involving monitoring the AIDS epidemic

TA - Technical assistance and prevention programs

ANE - Asian and Near Eastern countries

LAC - Latin American and Caribbean countries

Table 2

PRELIMINARY SUMMARY OF COUNTRY-SPECIFIC AIDS ACTIVITIES, FY 88

		TECHNICAL ASSISTANCE (1)						COMMODITIES PROVISION (2)		
COUNTRY	DONORS' MEETING SUPPORT THROUGH WHO/GPA	NEEDS ASSESS.	BLOOD	HCF	IEC	STD	SURV.	BLOOD TRANS. SCREEN.	CONDOMS	RESIDENT ADVISORS
AFRICA										
BOTSWANA		P							C	
BURKINA FASO			C		P			C	C	
BURUNDI		C			P		P		C	
CAMEROON					P				C	
C.A.R.									C	
CHAD										
CONGO									C	
GABON									C	
GAMBIA									C	

C-COMPLETED
P-PLANNED

(1) NEEDS ASSESS. -- Needs assessment visits
BLOOD -- Blood and blood safety
HCF -- Health care financing
IEC -- Information, education, communications
STD -- Sexually transmitted disease control
SURV. -- Epidemiological surveillance

(2) BLOOD TRANS. SCREEN. -- Blood transfusion screening equipment

COUNTRY	DONORS' MEETING SUPPORT THROUGH WHO/GPA	TECHNICAL ASSISTANCE						COMMODITIES PROVISION		RESIDENT ADVISORS
		NEEDS ASSESS.	BLOOD	HCP	IEC	STD	SURV.	BLOOD TRANS. SCREEN.	CONDOMS	
GHANA		C			P					
GUINEA-BISSAU									C	
ETHIOPIA	C									
I COAST		C			P				P	
KENYA	C	C	P	P	C/P	P				P
LESOTHO		P							C	
MALAWI			C							
MALI					P				P	
MAURITIUS									P	
MOZAMBIQUE									*	
NIGER									P	
NIGERIA		C			C				P	
RWANDA	C	C			P				C/P	
SENEGAL	C	C	C		P			P	C	

C-COMPLETED
P-PLANNED

2

COUNTRY	DONORS' MEETING SUPPORT THROUGH WHO/GPA	TECHNICAL ASSISTANCE						COMMODITIES PROVISION		RESIDENT ADVISORS
		NEEDS ASSESS.	BLOOD	HCP	IEC	STD	SURV.	BLOOD TRANS. SCREEN.	CONDOMS	
SIERRA LEONE					C				C	
SWAZILAND		P								
TANZANIA	C	C							C/P	P
TOGO									C	
UGANDA	C	C			P				C	
ZAIRE	C	C	P	P	C/P				P	
ZAMBIA	C								C/P	
ZIMBABWE					P					
ASIA-NEAR EAST										
INDONESIA		C			P					
NEPAL									P	
PHILIPPINES		C			C/P		P			P
SRI LANKA									C/P	

C-COMPLETED
P-PLANNED

COUNTRY	DONORS' MEETING SUPPORT THROUGH WHO/GPA	TECHNICAL ASSISTANCE						COMMODITIES PROVISION		RESIDENT ADVISORS
		NEEDS ASSESS.	BLOOD	HCF	IEC	STD	SURV.	BLOOD TRANS. SCREEN.	CONDOMS	
THAILAND		C			P					
LATIN AMERICA-CARIBBEAN										
BRASIL									C/P	
BOLIVIA		P							C	
DOM REP		C		P	P		P	P		P
E. CARIB	C	C		P	C/P		P	P	C	P
ECUADOR		C	P		C/P		C			
EL SALVADOR		C			P					
GUATEMALA		C	C					P		
HAITI		C			C/P					
JAMAICA		C			C/P	P				P
MEXICO		C		C	C/P		P			P
PERU		P								

C-COMPLETED
P-PLANNED

GPA 26/04/88

APPENDIX TABLE A

GLOBAL PROGRAMME ON AIDS

1988 RESOURCE SUMMARY

Status of undesignated pledges and funds received
as at 26/04/88

BALANCE AS AT JANUARY 1, 1988 (less unliquidated obligations)	$7,318,732 (a)

DONOR	received
Australia	$178,100
Canada	$4,076,885
Finland	$987,256
Japan	$200,000
New Zealand	$335,971
Norway	$2,380,839
Sweden	$2,015,103
Switzerland	$3,875,969
United Kingdom	$4,137,425
UNDP	$150,000
TOTAL	$18,337,548 (b)

	pledged
France	$354,600
Sweden	$6,440,678
United Kingdom	$4,137,425
United States	$15,000,000
Others	$900,000
UNDP	$2,650,000
TOTAL	$29,482,703 (c)

TOTAL OF PLEDGES AND FUNDS AVAILABLE:	$55,138,983 (d)= (a)+(b)+(c)
1988 EXPECTED RESOURCE REQUIREMENT	$66,200,000 (e)
AMOUNT STILL REQUIRED	$11,061,017 (f)=(e)-(d)

APPENDIX TABLE B

GLOBAL PROGRAMME ON AIDS
NATIONAL PROGRAMME SUPPORT

STATUS OF COLLABORATION WITH COUNTRIES AND AREAS
AS OF 27 APRIL 1988

TSA= Technical Services Agreement
STP= Short Term Plan
MTP= Medium Term Plan
Interested parties meeting= organised for fund raising.

========= Ongoing or planned
May 88 date planned
+++++++++ completed

NOTE: all figures shown are provisional and

R. A. C.	Country or Area	Assessment Visit	Short-term Plan	Immediate Support *	Medium-term Plan	Mobilization of Interested Parties	Responsible Adm.	Responsible Tech.	Initial visit ended	Government endorsement of STP recd	FSA sent to Govt	FSA returned to HQ	Funds sent	FSA starts	MTP visit ended	Donors' meeting held	MTP Budget 1988
	AFRICA																
X	1 Algeria	##########	#########	xxxxxxxxxx			GE	AL/AA	10-Jan-88	20-Jan-88							
X	2 Angola	##########	#########	##########	Jun-88		GE	BS/KY	15-Oct-87	03-Nov-87	21-Dec-87	19-Feb-88	29-Feb-88	01-Dec-87			
X	3 Benin	##########	#########	##########	Jun-88		BB	AL/NC	25-May-87	06-Jul-87	13-Aug-87	14-Sep-87	23-Sep-87	01-Aug-87			
X	4 Botswana	##########	#########	##########	##############	May-88	BB	PF/BS	03-Jul-87	04-Sep-87	14-Oct-87	25-Nov-87	22-Jan-88	01-Oct-87		To revise	$885,000
X	5 Burkina Faso	##########	#########	##########	Aug-88		BB	AA/NC	17-Aug-87	20-Aug-87	20-Dec-87	11-Jan-88	29-Feb-88	15-Dec-87			
X	6 Burundi	##########	#########	##########	##############	Jun-88	BB	AL/NC	20-May-87	13-Jul-87	21-Aug-87	02-Nov-87	10-Nov-87	01-Aug-87	07-Mar-88		$1,719,427
X	7 Cameroon	##########	#########	##########	##############	Jun-88	BB	PF/NC	06-Mar-87	23-Mar-87	02-Jun-87	23-Jun-87	17-Jul-87	01-Jun-87	18-Feb-88		$1,800,000
X	8 Cape Verde	##########	#########	##########			BB	AL/NC	30-Jun-87	07-Oct-87	10-Dec-87	06-Apr-88	25-Apr-88	01-Dec-87			
X	9 Central African Republic	##########	#########	##########	##############	Jun-88	BB	AG/SG	15-Jun-87	24-Jul-87	11-Aug-87	15-Oct-87	30-Oct-87	01-Aug-87	16-Feb-88		$1,399,050
	10 Chad	##########	#########	xxxxxxxxxx	Aug-88		GE	AA/NC	13-Dec-87	27-Jan-88							
X	11 Comoros	##########	#########	##########	Jul-88		BB	AL/AA	29-Sep-87	29-Sep-87	20-Dec-87	22-Feb-88	29-Feb-88	01-Dec-87			
X	12 Congo	##########	#########	##########	##############	Jun-88	BB	AA/NC	27-Mar-87	29-May-87	31-Aug-87	06-Oct-87	08-Oct-87	01-Aug-87	11-Feb-88		$1,730,620
X	13 Cote d'Ivoire	##########	#########	##########	xxxxxxxxxxxxxx		GE	AL/SG	26-Jun-87	26-Oct-87	24-Mar-88	01-Apr-88	25-Apr-88	01-Dec-87			
	14 Equatorial Guinea	##########	#########	xxxxxxxxxx			GA	EV/AL	19-Dec-87								
X	15 Ethiopia	##########	#########	##########	##############	##############	BB	PF/SG	13-Mar-87	13-Mar-87	03-Jun-87	22-Sep-87	12-Oct-87	01-Jun-87	29-May-87	04-Aug-87	$1,370,000
X	16 Gabon	##########	#########	##########	Aug-88		BB	AL/SG	07-Jul-87	20-Oct-87	30-Nov-87	15-Dec-87	22-Jan-88	01-Dec-87			
X	17 Gambia	##########	#########	##########	Aug-88		BB	PF/BS	17-Jun-87	17-Jun-87	23-Sep-87	03-Nov-87	10-Nov-87	01-Sep-87			
X	18 Ghana	##########	#########	##########	Jun-88		BB	PF/BS	30-Jun-87	24-Jul-87	UNDP funded		16-Oct-87	01-Oct-87			
X	19 Guinea	##########	#########	##########	##############		GE	SG/AL	23-Jul-87	10-Aug-87	21-Dec-87	21-Jan-88	29-Jan-88	01-Dec-87			
X	20 Guinea-Bissau	##########	#########	##########	May-88		BB	SG/NC	25-May-87	29-May-87	13-Aug-87	14-Sep-87	21-Sep-87	01-Aug-87			
X	21 Kenya	##########	#########	##########	##############	##############	EB	BS/ES	10-Jan-87	27-Jan-87	27-Feb-87	09-Jul-87	21-Jul-87	01-Mar-87	01-Apr-87	31-Jul-87	$2,055,750
X	22 Lesotho	##########	#########	##########	##############	xxxxxxxxxxxxxx	EB	PF/BS	20-Jul-87	27-Jul-87	17-Oct-87	29-Oct-87	02-Nov-87	01-Oct-87	23-Jan-88		$1,353,600
X	23 Liberia	##########	#########	##########	Jul-88		BB	GS/BS	15-Aug-87	16-Sep-87	06-Oct-87	30-Nov-87	05-Jan-88	01-Aug-87			
X	24 Madagascar	##########	#########	xxxxxxxxxx			BB	AA/NC	24-Sep-87	29-Feb-88				I			
X	25 Malawi	##########	#########	##########	##############	xxxxxxxxxxxxxx	GE	BS/BS	17-Aug-87	10-Sep-87	19-Oct-87	27-Oct-87	10-Nov-87	01-Oct-87	27-Feb-88		
X	26 Mali	##########	#########	##########	##############		BB	AL/AA	26-Jun-87	26-Jun-87	12-Nov-87	09-Feb-88	25-Feb-88	01-Nov-87			
	27 Mauritania	##########	#########	xxxxxxxxxx			BB	AA/NC	21-Jan-88								
X	28 Mauritius	##########	#########	##########	##############	May-88	BB	AA/PS	04-Apr-87	10-Jul-87	12-Aug-87	15-Oct-87	10-Nov-87	15-Jul-87	03-Jul-87		$273,000
X	29 Mozambique	##########	#########	##########	##############	##############	EB	PF/BS	09-Mar-87	09-Mar-87	17-Jun-87	13-Jul-87	06-Jul-87	01-Jun-87	08-Aug-87	19-Apr-88	$2,320,000
	30 Namibia (SWAPO)	##########	xxxxxxxxx	xxxxxxxxxx				PF/BS									
X	31 Niger	##########	#########	##########	Jun-88		BB	AL/SG	03-Jul-87	03-Jul-87	14-Aug-87	03-Sep-87	10-Sep-87	01-Aug-87			
X	32 Nigeria	##########	#########	##########	Aug-88		BB	PF/KY	03-Mar-87	10-Mar-87	11-May-87	11-Jan-88	10-Mar-88	01-Jun-87			
X	33 Rwanda	##########	#########	##########	##############	##############	GE	AL/NC	23-May-87	23-May-87	11-Aug-87	11-Aug-87	10-Sep-87	01-Jul-87	23-May-87	20-Jul-87	$1,332,000
X	34 Sao Tome et Principe	##########	#########	xxxxxxxxxx			EB	SG/NC	08-Dec-87								
X	35 Senegal	##########	#########	##########	##############	##############	BB	AL/NC	14-Jul-87	14-Jul-87	08-Sep-87	30-Dec-87	15-Jan-88	01-Sep-87	14-Jul-87	15-Feb-88	$200,000
X	36 Seychelles	##########	#########	##########			BB	AA/SG	04-Oct-87	23-Oct-87	16-Dec-87	24-Feb-88	25-Mar-88	01-Dec-87			
X	37 Sierra Leone	##########	#########	##########	Jul-88		EB	BS/GS	20-Jun-87	12-Aug-87	24-Sep-87	30-Oct-87	10-Nov-87	01-Sep-87			
	South Africa																
X	38 Swaziland	##########	#########	##########	xxxxxxxxxxxxxx		EB	PF/BS	10-Jul-87	04-Sep-87	15-Oct-87	08-Feb-88	25-Feb-88	15-Oct-87			
X	39 Togo	##########	#########	##########			BB	AL/NC	07-Aug-87	11-Jan-88	29-Feb-88	30-Mar-88	19-Apr-88	01-Jun-88			
X	40 Uganda	##########	#########	##########	##############	##############	EB	GS/BS	17-Jun-87	01-Mar-87	05-Mar-87	02-Apr-87	30-Apr-87	01-Mar-87	17-Feb-87	22-May-87	$4,272,000
X	41 United Republic of Tanzania	##########	#########	##########	##############	##############	EB	AL/SG	13-Mar-87	01-Apr-87	02-Jun-87	02-Jul-87	13-Jul-87	01-Jun-87	27-Jun-87	24-Jul-87	$4,314,000
X	42 Zaire	##########	#########	##########	##############	##############	BB	AA/NC	04-Apr-87	08-Apr-87	23-Jun-87	15-Aug-87	30-Aug-87	01-Jul-87	17-Sep-87	11-Feb-88	$1,700,000
X	43 Zambia	##########	#########	##########	##############	##############	GE	EV/PF	08-Sep-86	20-Feb-87	02-Mar-87	01-Apr-87	11-Jun-87	01-Mar-87	03-Aug-87	16-Mar-88	$2,315,000
X	44 Zimbabwe	##########	#########	##########	##############	Jul-88	EB	PF/BS	29-Aug-87	11-Sep-87	19-Oct-87	09-Nov-87	18-Nov-87	01-Nov-87			
	Subtotal	44	43	37	20	9											

B. A. C.	Country or Area	Assessment Visit	Short-term Plan	Immediate Support *	Medium-term Plan	Mobilization of Interested Parties	Responsible Adm.	Tech.	Initial visit ended	Government endorsement of STP recd	ISA sent to Govt	ISA returned to HQ	Funds sent	ISA starts
	SOUTH-EAST ASIA													
X	1 Bangladesh	0000000000	000000000	:::::::::::				PS/GS	04-Feb-88					
	2 Bhutan	::::::::::												
X	3 Burma	0000000000	000000000	:::::::::::				PS/PF	19-Feb-88					
	4 DPR Korea	0000000000	000000000					PS/JJ						
X	5 India	::::::::::						PS/AB						
X	6 Indonesia	0000000000	000000000	:::::::::::	Jul-88		CC	PS/ML	05-Dec-87	07-Jan-88	1			
X	7 Maldives	0000000000	000000000	:::::::::::				PS/DS	13-Feb-88					
X	8 Mongolia	0000000000	000000000	00000000000	Jul-88		EB	PS/JJ	10-Sep-87	10-Sep-87	02-Nov-87	18-Jan-88	25-Feb-88	01-Nov-87
X	9 Nepal	0000000000	000000000	00000000000	Sep-88		GE	PS/EV	31-Jul-87	09-Sep-87	25-Nov-87	12-Jan-88	29-Jan-88	01-Dec-87
X	10 Sri Lanka	0000000000	000000000	00000000000	Jun-88		EB	PS/DS	20-Jul-87	21-Sep-87	09-Nov-87	24-Nov-87	30-Dec-87	01-Dec-87
X	11 Thailand	0000000000	000000000	:::::::::::	Jul-88		GO	PS/AB	17-Dec-87					
	Subtotal	9	9	3	0	0								
	EASTERN MEDITERRANEAN													
X	1 Afghanistan	0000000000	000000000	00000000000			EB	DS/JJ	10-Oct-87	10-Oct-87	26-Nov-87	23-Dec-87	27-Jan-88	01-Dec-87
X	Bahrain													
X	2 Cyprus	::::::::::												
X	3 Democratic Yemen	0000000000	000000000	00000000000	::::::::::::::		DD	PS/DS	21-Aug-87	23-Aug-87	11-Nov-87	21-Dec-87		01-Oct-87
X	4 Djibouti	0000000000	000000000	:::::::::::				AR/AL	22-Dec-87	20-Jan-88				
X	5 Egypt	0000000000	:::::::::				EB	SG/DS	03-Dec-87					
X	6 Iran	0000000000	000000000	00000000000	Aug 88		EB	DS/GS	28-Aug-87	10-Nov-87	21-Dec-87	17-Feb-88	29-Feb-88	01-Dec-87
X	Iraq													
X	7 Jordan	0000000000	000000000	00000000000	::::::::::::::		DD	SG/DS	13-Aug-87	23-Nov-87	18-Dec-87	18-Jan-88	29-Jan-88	01-Dec-87
X	8 Kuwait	0000000000						DS/AL						
X	Lebanon	0							SUPPLIES FROM EM-IS					
X	9 Libyan Arab Jamahiriya	0000000000	000000000					SG/DS	12-Apr-88					
X	10 Morocco	::::::::::						AL/MC						
X	11 Oman	0000000000	000000000					PF	24-Mar-88					
	12 Pakistan	::::::::::						DS	SUPPLIES FROM EM 88					
	Qatar													
	13 Saudi Arabia	::::::::::						DS						
X	14 Somalia	0000000000	000000000	:::::::::::				DS/GS	08-Feb-88					
X	15 Sudan	0000000000	000000000	00000000000	Jun-88		GE	PS/DS	19-Aug-87	19-Aug-87	10-Nov-87	27-Nov-87	09-Dec-87	01-Nov-87
X	16 Syrian Arab Republic	0000000000	000000000	00000000000	::::::::::::::		DD	DSI/SG	20-Aug-87	08-Sep-87	10-Dec-87	20-Jan-88	10-Feb-88	01-Dec-87
X	17 Tunisia	0000000000	000000000	00000000000			DD	AL/SG	29-Aug-87	14-Dec-87	31-Mar-88			
	18 United Arab Emirates	::::::::::						SG/DS						
	19 Yemen	0000000000	000000000				FB	DS/PS	19 Dec 87					
	Subtotal	10	12	7	0	0								

R. A. C.	Country or Area	Assessment Visit	Short-term Plan	Immediate Support *	Medium-term Plan	Mobilization of Interested Parties	Responsible Adm.	Tech	Initial visit ended	Government endorsement of STP recd	TSA sent to Govt	TSA returned to HQ	Funds sent	TSA starts
	EUROPE													
E	1 Albania	••••••••••	•••••••••	••••••••••			DD	SG	29-Aug-87	19-Oct-87	10-Nov-87	30-Nov-87	NA	01-Oct-87
E	Austria													
E	Belgium													
E	2 Bulgaria	••••••••••	•••••••••					EV	30-Sep-87					
E	Czechoslovakia													
E	Denmark													
E	Finland													
E	France													
E	German Democratic Republic													
E	Germany, Federal Republic of													
E	3 Greece	••••••••••	•••••••••	::::::::::			CO	DSE	26-Sep-87	20-Jan-88				
E	Hungary													
E	4 Iceland	••••••••••							27-Jun-87					
E	Ireland													
E	5 Israel	••••••••••						PF	10-Dec-87					
E	Italy													
E	Luxembourg													
E	Malta													
E	Monaco													
E	Netherlands													
E	Norway													
E	Poland													
E	Portugal													
E	Romania													
E	Spain													
E	Sweden													
E	Switzerland													
E	6 Turkey	::::::::::						JJ	06-Aug-87					
E	7 USSR	••••••••••												
E	United Kingdom													
E	Yugoslavia													
	Subtotal	6	3	1	0	0								

B. A. C.	Country or Area	Assessment Visit	Short-term Plan	Immediate Support *	Medium-term Plan	Mobilization of Interested Parties	Responsible Adm. Tech	Initial visit ended	Government endorsement of SIP recd	ISA sent to Govt	ISA returned to HQ	Funds sent	ISA starts
	AMERICAS												
	Anguilla		░░░░░░░░░										
	1 Antigua and Barbuda	██████████	░░░░░░░░░	░░░░░░░░░░	May/June 88		EV/DSI						
X	2 Argentina	██████████	█████████	██████████	██████████████		EV/DSI						
X	3 Bahamas	██████████	█████████	██████████	June/July 88		EV/DSI						
X	4 Barbados	██████████	█████████	██████████			EV/DSI						
X	5 Belize	██████████	█████████	██████████	Sep-88		EV/DSI						
X	6 Bermuda	██████████	░░░░░░░░░	░░░░░░░░░░	Apr-88		EV/DSI						
X	7 Bolivia	██████████					EV/DSI						
X	8 Brazil	██████████	█████████	██████████	██████████████	UNP Jan donor	EV/DSI						
	9 British West Indies**	██████████		██████████			EV/DSI						
X	Canada												
	10 Cayman Islands**	██████████	█████████	██████████		Fall	EV/DSI						
X	11 Chile	██████████	█████████	░░░░░░░░░░			EV/DSI						
	12 Colombia	██████████					EV/DSI						
X	13 Costa Rica	██████████		Jan-88	██████████████		EV/DSI						
X	14 Cuba	██████████	█				EV/DSI						
	15 Dominica	██████████	█████████	██████████	Jan-88	Fall	EV/DSI						
X	16 Dominican Republic	██████████	█████████	██████████	May/June 88		EV/DSI						
X	17 Ecuador	██████████			██████████████		EV/DSI						
X	18 El Salvador	██████████	█████████	██████████			EV/DSI						
X	19 Grenada	██████████	█████████	██████████	May-88		EV/DSI						
X	20 Guatemala	░░░░░░░░░░		Jan-88			EV/DSI						
X	21 Guyana	██████████	█████████	██████████	Apr-88		EV/DSI						
X	22 Haiti	██████████	█████████	██████████			EV/DSI						
X	23 Honduras	██████████					EV/DSI						
X	24 Jamaica	██████████	█████████	██████████	May-88		EV/DSI						
X	25 Mexico	██████████	█████████	██████████	██████████████		EV/DSI	14-Jul-87					
	26 Netherlands Antilles and Aruba**	██████████											
X	27 Nicaragua	░░░░░░░░░░					EV/DSI						
X	28 Panama	██████████		Jan-88			EV/DSI						
X	29 Paraguay	██████████					EV/DSI						
X	30 Peru	██████████					EV/DSI						
	31 Saint Christopher and Nevis	██████████	░░░░░░░░░	░░░░░░░░░░			EV/DSI						
X	32 Saint Lucia	██████████			Apr 88		EV/DSI						
	33 Saint Vincent and the Grenadines	██████████	░░░░░░░░░	░░░░░░░░░░	Jul-88		EV/DSI						
X	34 Suriname	██████████	█████████	██████████	██████████████		EV/DSI						
X	35 Trinidad and Tobago	██████████		██████████	██████████████		EV/DSI						
	36 Turks and Caicos Islands**	██████████	█████████	██████████	░░░░░░░░░░░░░░		EV/DSI						
X	37 United States of America	░░░░░░░░░░					EV/DSI						
X	38 Uruguay	██████████			██████████████		EV/DSI						
X	39 Venezuela	██████████		██████████	░░░░░░░░░░░░░░		EV/DSI						
	Subtotal	36	17	19	8	0							

N. A. C.	Country or Area	Assessment Visit	Short-term Plan	Immediate Support *	Medium-term Plan	Mobilization of Interested Parties	Responsible Adm.	Responsible Tech	Initial visit ended	Government endorsement of SIP recd	TSA sent to Govt	TSA returned to HQ	Funds sent	TSA starts
	WESTERN PACIFIC													
	American Samoa**													
X	1 Australia	##########						GS/EV						
X	Brunei Darussalam													
X	2 China	##########					EB	AR/AL	05-Mar-88					
	3 Cook Islands	##########	#########	##########			BD	GS/EV	05-Dec-87					
	Democratic Kampuchea							AB						
X	4 Fiji	##########						GS/FF						
X	French Polynesia**													
	5 Guam**	##########					EB	GS/EV						
X	Hong Kong**													
X	6 Japan	##########						GB						
	7 Kiribati	##########	#########	##########			GE	GS/EV	20-Nov-87					
	Lao People's Dem. Rep.						GE	AL/DB						
	8 Macau**	##########												
X	9 Malaysia	##########						PS/RS						
	10 Marshall Islands**	##########	#########	##########			GE	GS/EV	12-Jan-88					
	11 Nauru**	##########					EB	GS/EV						
X	New Caledonia**													
X	New Zealand							GS						
	12 Niue**	##########						GS/EV						
X	13 Papua New Guinea	##########	#########	##########			GE	GS/EV	16-Dec-87					
X	14 Philippines	##########			##############			SS/RS						
X	Republic of Korea							PS/JJ						
	15 Saipan	##########						GS/EV						
X	16 Samoa	##########	#########	##########			GE	GS/EV	20-Nov-87					
X	17 Singapore	##########												
	18 Solomon Islands	##########	#########	##########			GE	GS/EV	29-Nov-87					
	Tokelau**													
	19 Tonga	##########	#########	##########			GE	GS/EV	30-Nov-87					
	20 Trust Terr. of the Pacific Isl.**	##########												
	21 Tuvalu**	##########												
X	22 Vanuatu	##########	#########	##########			GE	GS/DS	08-Dec-87					
X	23 Viet Nam	##########						AR/AL						
	Subtotal	23	8	8	1	0								
	TOTAL	121	99	67	29	9								

143 countries have requested collaboration:

- 44 in Africa
- 39 in the Americas
- 11 in South-East Asia
- 19 in the Eastern Mediterranean
- 7 in Europe
- 23 in the Western Pacific

ADDITIONAL QUESTIONS FOR BRADSHAW LANGMAID

Submitted by Hon. Mickey Leland

USE OF AIDSCOM AND AIDSTECH

Mr. Leland: Mr. Langmaid, has A.I.D. considered using AIDSCOM and AIDSTECH as primarily conduits of assistance to NGOs and PVOs? It seems to me that the large contractors hired for the work could be more effective if they provided technical assistance and support to organizations working at the grassroots level. Have you considered making this the focus of these two programs?

Answer: The Agency for International Development (A.I.D.) has a two-part strategy for ensuring the involvement of non-governmental organizations in AIDS prevention in developing countries. AIDSCOM and AIDSTECH are involved in both parts. First, through the AIDSTECH agreement, we will be funding grants for PVO projects on AIDS. PVOs are uniquely placed to perform interventions and conduct applied research, surveillance and training, and are being encouraged to submit proposals to AIDSTECH for funding. To date, however, PVOs have been only minimally involved in AIDS prevention in developing countries, and these "seed" grants are designed to facilitate greater involvement. Grants will normally be limited to $50,000 with average life of project of one to two years (maximum). The first review began July 1, 1988, and will be followed by further calls for proposals and reviews every three months. PVOs will be informed of the review outcome within three to four weeks after the deadline for submission.

Second, A.I.D. will continue to encourage development of substantial country-level PVO programs. AIDSTECH and AIDSCOM have provided and will continue to provide technical assistance and financial support to NGOs and PVOs at the country level. A project presently underway in Haiti provides a good example of AIDSCOM/AIDSTECH/PVO interaction.

USAID/Haiti requested technical assistance from AIDSCOM to develop further an AIDS education and prevention project submitted by a Haitian PVO--GLAS (Groupement de Lutte Anti-SIDA). In brief, the project comprises three major elements: (1) education; (2) condom distribution; and (3) counselling. The project, budgeted at $210,000 for one year with expected extension for 3-5 years, will reach an estimated 20,000 workers in 20-50 factories in Port-au-Prince. The industrial worker sector is well represented by

GLAS and is its natural constituency. AIDSCOM played a key technical assistance role in the design of the project and will continue to assist in its implementation.

As the AIDS program at A.I.D. continues to develop, and as technical assistance is provided to more developing countries in the coming years, we hope to see this model copied in many countries. It reaches people at the grassroots level and through their peers. This is especially important since it involves communicating in a culturally sensitive manner.

PROJECTED GOVERNMENT FUNDING

Mr. Leland: In 1987, there were 87,000 cases of AIDS reported worldwide. By 1992, it is projected that there will be 1.2 million cases. Can you give us any projections on how much U.S. Government funding will be required to contribute adequately to AIDS efforts four years from now given this sort of explosion in the numbers of AIDS cases?

Answer: At this time it is very difficult to give you a reliable estimate on funding requirements four years hence. We look to the World Health Organization's Global Program on AIDS (WHO/GPA) to provide the program funding framework for meeting the AIDS epidemic. Their strategy for addressing the AIDS problem at the country level is the development, with that country, of a short-term program, followed by an intermediate 3-5 year program. WHO/GPA funds the requirements for the short-term plan out of its own resources, but the 3-5 year intermediate plan becomes the framework within which all donors are asked to coordinate their assistance. WHO/GPA has had requests for assistance from over 140 countries. To date it has provided emergency assistance to over 120 countries and developed agreed-upon intermediate plans for 25 countries. Pledging sessions have been held for 10 countries. After pledging sessions have been held in more A.I.D.-assisted countries, we will be able to provide a more reliable estimate of program requirements and project those requirements into the future for the length of time you have requested.

ASSISTANCE REQUESTS TO AIDSTECH AND AIDSCOM

Mr. Leland: Mr. Langmaid, I understand that AIDSTECH and AIDSCOM are receiving far more requests for assistance than they can respond to. Is this true? Could you tell us how much money AIDSTECH and AIDSCOM have available relative to the requests they are receiving?

Answer: At present we have obligated $10 million to these two projects in FY 1988. Additional demand cannot be quantified, but it is normal in any A.I.D. project to find that country demands for additional funds or activities exceed the scope provided for.

A.I.D. continues to monitor country needs, and how those needs can be addressed by A.I.D., WHO and host governments, with a view to preparing a responsible request to Congress for AIDS funding.

FUNDS BREAKDOWN: AIDSCOM AND AIDSTECH

Mr. Leland: Could you give the Committee a breakdown of how the funds provided to AIDSCOM and AIDSTECH have been spent so far? Specifically, how much has been spent in the U.S. and how much has been spent in the Third World?

Answer: Both AIDSCOM and AIDSTECH have recently formulated work plans to carry them through their first 18 months of operation. For AIDSTECH, from September 1987 through March 1989, the estimated ratio of field activity costs to total costs is 71 percent. For AIDSCOM, from September 1987 through March 1989, the ratio of field activity costs to total costs is 62 percent. These ratios reflect the substantial start-up costs necessary with any new program--the design costs for travel and consultants associated with the planning stage of field activities.

FUNDING POLICY FOR AIDS

Mr. Leland: We are very concerned about the impact that AIDS will have on spending for ongoing development assistance programs. Will the Agency develop a policy on when funds for programs such as health, population, and child survival can be spent on AIDS activities and how much funding from these programs can go to AIDS prevention and education? I understand that it is often difficult to distinguish AIDS-related programs from regular assistance programs, but could you quantify for the Committee the impact that AIDS is having on our development assistance efforts?

Answer: The policy of the Agency is that the funds made available by the Congress through the AIDS account should be used for activities which are specifically directed at the control and prevention of AIDS. However, we recognize that AIDS is also a population issue and a health issue. When the AIDS threat impinges on or will affect the implementation of a health activity or a population activity, we expect those accounts to assume the incremental costs. For example, in a training program for nurses and midwives dealing with sexually-transmitted diseases, it is obvious that discussion of AIDS now needs to be included in the training syllabus. We would expect the Health, Population, ESF, or DFA accounts, as appropriate, to absorb this incremental cost. For this reason, we have not set aside a specific sum from any of these accounts for AIDS activities.

In FY 1987, we estimated that approximately $3 million was spent from other accounts on AIDS-related activities. In FY 1988, our estimate is $5 million. We expect this number to grow slightly in FY 1989. If anything, these levels may underestimate the cost inasmuch as some of the AIDS-related expenditures are so incremental in character, such as additional disinfectant, that it is impractical to account for them separately.

PREPARED STATEMENT OF MICHAEL S. GERBER, PH.D, PRESIDENT, AFRICAN MEDICAL & RESEARCH FOUNDATION, AMREF/USA

Mr. Chairman, members of the Select Commitee on Hunger, I am Michael Gerber, President of the African Medical & Research Foundation (AMREF). AMREF appreciates the opportunity to appear before you today.

This testimony will present a brief overview of the AIDS crises in Africa and the potential implications of the epidemic on development. After identifying the current status of AIDS in Africa as we see it, a statement is presented on the political ramifications of the disease. This is followed with a description of AMREF and our interventions in response to AIDS. Specific references are then made to the impact of AIDS on: economic development; the social fabric of society; existing health infrastructures, and; women and children. I conclude with some general comments on the integration of AIDS activities with other programs and the need to involve private voluntary organizations in efforts to curb transmission.

AIDS IN AFRICA: It is estimated that two-three million people in Africa are carrying the AIDS virus and conservative figures place deaths since the epidemic began at 50,000. Privately, it has been stated that deaths might be as high as several hundred thousand. Current projections point out that between 10 and 30 percent of the people exposed to the virus can be expected to develop the disease within 5 years, and up to 50% in 7 to 8 years. This could mean in the near future, 1.5 million more persons with AIDS based on existing infections alone. During the past year, virtually every African country reported AIDS to the World Health Organization (WHO) although the reported cases are far below the estimates. Through

April of 1988, 44 African nations reported 10,583 cases.

AIDS is endemic in much of Central and East Africa. Evidence from studies done in Zaire, Rwanda, Burundi, Tanzania, Uganda, and Kenya prove the virus has already infected substantial segments of the young adult population in these countries and there are a growing number of cases who have developed AIDS. The prevalence of infection among women of childbearing age presents a potentially devastating set of problems. Four through 15% of adult women in some endemic areas are believed to be positive. Hospital studies in a number of the above countries are showing that in some cases, 50% of the infants born to infected mothers are themselves infected with the HIV virus. Given current trends, there is the prospect of a vast pool of orphaned children, many of whom will themselves face a bleak future.

The distribution of AIDS cases reflects the prevalence of infection in these areas but is, in itself, only the tip of the iceberg. It is assumed that there are 50-100 infected individuals for each clinical case. This large pool of unidentified but infected men and women represents the greatest hazard for transmission and spread of the epidemic. The pattern of AIDS cases differ somewhat from country to country, but there is an overall picture that is consistent in its most important features.

Specifically, AIDS in Africa is best understood as a sexually transmitted disease. While the experience in the USA and Europe is that AIDS began among homosexual and I.V. drug abusers, these groups are not significant factors in Africa. Rather, the prevalence and distribution of AIDS cases in Africa suggest widespread, bi-directional heterosexual transmisson as the principle route of spread of this infection.

Cases are divided equally between male and female. Incidence peaks in the sexually active years and retrospective studies of heterosexual contacts of AIDS victims reveal high rates of infection. In addition, high prevalence rates have been found among prostitutes in Kenya, Uganda and Zaire. In Kenya, prospective studies show these rates are rising rapidly. The speedy transmission of the AIDS virus can be attributed to frequent, multi-partner heterosexual activity. The high incidence of other sexually transmitted diseases in certain African countries is also a consideration in the transmission of AIDS.

Additional factors seem to play an important role in this epidemic. As many as 10% of blood donors have been found positive in endemic areas and, given practices of frequent transfusion, this forms another important route of transmission of the infection. Past studies in Kampala, the capital of Uganda, showed 11% of donor blood is sero-positive. The high rate of infection combined with the medical practice of ordering frequent blood transfusions in East Africa can be identified as important elements in the spread of HIV.

Medical injections with inadequately sterilized needles seem likely to be another significant means of spread. Indeed, studies show higher prevalence of infection among those with histories of large numbers of injections. In this regard, there is definite concern for child immunization programs in Africa. WHO, USAID, Britain's ODA, and other donor agencies have been promoting campaigns against measles, tetanus, whooping cough, and other childhood diseases. Vaccines normally stimulate the body's defense system to produce antibodies against the target disease. Children, whose immune systems can be broken down by AIDS, may be unable to produce such antibodies. Moreover, the effect of immune stimulation among HIV infected youngsters is not yet well understood but may, of course, be dangerous.

AIDS IN AFRICA - A SENSITIVE ISSUE: In a number of African countries, there is great concern over certain issues associated with the AIDS epidemic. Two in particular have received widespread attention. These are (1) arguments over the origins of the disease and (2) unauthorized publication of AIDS research studies conducted in Africa by non-Africans. Particularly in poorer countries with heavy dependence on trade and tourism, there must be a recognition of the sensitivities and perceptions of governments and the public. Just as in the U.S., there is also a political reality to AIDS in Africa.

In order for any organization to successfully undertake AIDS programs in Africa, local concerns must be a number one priority. In the countries where AMREF is active, namely Kenya, Tanzania, and Uganda, there has been a change in the AIDS political climate over the last few months. National AIDS Committees have been established. They are defining the problem and developing strategies to curb transmission. There is greater recognition of the potential magnitude of the problem and a commitment to seeking resources, both human and financial, to assist in curbing transmission. These developments are, however, progressing at different speeds in the various countries. In order to provide effective assistance, an organization must be acutely aware of sensitivities and understand how to operate culturally. By necessity, a number of private voluntary agencies have had such characteristics.

AMREF AND AIDS: AMREF is a private voluntary organization that was founded in the United States in 1957. With its field headquarters in Nairobi, Kenya, AMREF has been working for over 30 years to improve the health of the rural poor in East Africa. AMREF's field staff today numbers more than 600, of whom 93% are African. Over 40 distinct projects are being carried out in the areas of public health, health training, clinical services, research, and health learning materials development. AMREF currently has activities in Kenya, Uganda, Sudan, Somalia and Tanzania. In the past, activities have been undertaken in Ethiopia, Zambia, Zimbabwe, Botswana, Lesotho, Malawi, and Zanzibar.

One important factor which distinguishes AMREF from other PVOs is its firm roots in the field. Rather than develop a large institutional base in New York, AMREF established its technical support capabilities in East Africa. This has resulted in AMREF being viewed by governments, UN agencies, and non-governmental organizations as a non-political, internationally sponsored regional resource. It is a position which permits and encourages collaboration and communication across national boundaries.

Perhaps AMREF's greatest strength lies in its health education programs. A whole range of outreach, regional training, materials production, and clinical programs keep AMREF in touch with literally thousands of health workers. In addition, AMREF has the largest two-way radio system in Africa, linking remote health centers to Nairobi headquarters.

Few organizations, government or PVO, are better positioned to respond to the AIDS problem in Africa than AMREF. Our programs are carried out in close collaboration with Ministries of Health in all of the above mentioned countries. AMREF has also provided technical assistance to various governments and has helped carry out national level continuing health education programs in Kenya, Uganda, and Tanzania. Representatives from government and donor agencies join AMREF staff on all project oversight committees. Official relations and working relationships are maintained with the World Health Organization and UNICEF. Any AIDS interventions undertaken by AMREF are only done with complete concurrence of government, research institutes such as the Kenya Medical Research Institute, National AIDS Committees, national government hospitals such as Kenyatta in Kenya and Mulago in Uganda, and in cooperation with WHO.

Backing has been received for AMREF's AIDS program from the Kenya Medical Research Institute, the Kenya National Committee on AIDS, the Health Education Division of Kenya's Ministry of Health, and the Director of Medical Services of Uganda's Ministry of Health.

To date, three of AMREF's departments have been implementing a number of AIDS projects. Of prime importance is the Health Behavior and Education Department. One staff member sits on the Health Education Subcommittee of Kenya's National AIDS Commission. Others produce a variety of health education materials. These appear in AMREF publications such as Defender and in a twice weekly newspaper article published in the Kenyan daily, Standard. The column is entitled "Dr. AMREF". In cooperation with other AMREF departments and Uganda's Ministry of Health, a booklet entitled "Avoid AIDS" has been produced.

The Clinical Department has been able to take advantage of AMREF's existing services to rural health facilties in East Africa.

While not yet able to do the desperately needed scientific community based sero-prevalence surveys, random blood samples have been collected for HIV testing. An epidemiologist with AIDS experience has been added to the department. He will play a key role when permission is granted and resources become available for community based surveys. A number of workshops have been held to train laboratory technicians in Uganda and Tanzania.

AMREF's Training Department has, for a number of years, been offering correspondence courses for rural health workers. As a result, it has established links to a vast number of isolated rural health workers. The Training Department has the means and reach to educate this large number of health providers who are the backbone of African health systems. We fill a gap for continuing education because governments often do not have the resources to upgrade the skills of those in service. AMREF has developed an AIDS component which has been integrated into these distance teaching modules.

AMREF's responses to date have been limited by two factors - the caution of African governments in developing their national programs and most importantly, by a lack of funds. In anticipation that these constraints will ease, AMREF has developed a three part program which could increase our involvement dramatically. The components to our proposed program include: increased health education efforts; additional training; epidemiological prevalence surveys.

AMREF's health education efforts will concentrate on slowing the transmission of AIDS by focusing on the following: (1) Training all cadres of rural health workers to help in limiting AIDS transmission via community education campaigns (2) The promotion of contraception which prevents sexual transmission of the AIDS virus (3) Promoting health treatment practices (i.e. needle use) that are safe (4) Creating an environment for the more restricted use of blood transfusions, and eventual protection of the blood supply (5) Developing laboratory capabilities to allow the screening of blood for the AIDS virus.

More specifically, AMREF will concentrate on the preparation of appropriate health education materials for various cadres of health workers and community groups, the distribution of prepared materials, the promotion of AIDS control through use of radio and other mass media, behavioral change to help reduce transmission, the promotion of safe sex practices, conducting workshops for laboratory technicians on techniques for proper testing of blood samples.

When requested, AMREF has the infrastructure and personnel in the field ready to assist governments conduct sero-prevalence surveys focusing on targeted rural and urban areas. We hope to address the following: the issue of prevalence, attempting to identify routes and factors that determine the distribution of viral infection; the risk factors for viral infection; the natural history of AIDS from viral infection to disease as well as the course of the disease itself. Using a hospital and health center network that has been built up over 30 years, AMREF's clinical staff will continue to collect blood samples. In addition, utilizing the links through our community based health care projects, population based data will be collected. Village health workers will be mobilized to help determine behavioral patterns.

AIDS - THE IMPACT ON DEVELOPMENT: The consequences of AIDS go far beyond health statistics. Given the heterosexual nature of transmission and the 1:1 male-female ratio of HIV infection, the economic and social effects may be critical in a number of African countries. Deaths from AIDS will occur among the sexually active which usually includes those in the 20 to 45 age group. However, the growing number of teenage pregnancies in countries such as Kenya, Tanzania, and Uganda attest to a broader sexually active range - perhaps 15 to 45. Most other diseases in the developing world largely kill the very young and the aged.

AIDS has the potential to raise mortality rates several-fold among the economically and most socially productive age groups. Developing nations stand to lose people who are their greatest resource. AIDS will no doubt seriously hamper both industrial and agricultural production. Given the subsistence, labor intensive agriculture in many African countries, food production may be significantly reduced. The implications for standards of nutrition are also obvious.

In most African countries, trained manpower is already in short supply. Certain industries stand to lose key personnel. A sample of workers in a central African mining town taken in 1986 showed 68% of skilled male mineworkers testing positive for HIV. Contract workers in industry and agriculture are extremely vulnerable. Many work away from their families and indulge in casual sex or visit prostitutes. AIDS epidemics in export industries can affect both potential foreign exchange earnings and international commodity prices.

The AIDS epidemic can be devastating to the traditional African societal structure. Given the lack of government resources in most developing countries, the extended "family" or "group" provides the kind of social security system that public support makes available in the developed world. In Africa, the very young, the old, the sick, and disabled are often totally dependent on the age group most at risk from AIDS. Some AMREF staff members recently visited a village in East Africa where 90% of the adult population has died and only young children and old people are left.

The increased burden that AIDS will place on the existing health care systems in Africa will be far beyond the abilities of countries to cope. The annual health budgets in many countries ranges from $1 to $5 per capita. Some hospitals are today being flooded with AIDS patients. These hospitals are already overburdened and the result is less care for those suffering from other illnesses. A single blood test in Africa averages between $1 to $4 and a machine for testing blood samples can cost up to $15,000. The United States surgeon general has estimated that annual health costs of treating AIDS patients in this country could reach has high as 16 billion dollars by 1991. We already know the strain this places on America's vast resources. How can the much more limited health services of Uganda, Tanzania, or Kenya respond?

In some African countries, children comprise as many as one-third of all AIDS cases. The HIV epidemic could seriously affect gains made in infant mortality and child health through recent "child survival" programs. The epidemic among children can be attributed to a number of factors which include as many women being infected as men and very high birth rates.

Perinatal transmission is the dominant route of HIV infection in young children. The infection can be transmitted to the fetus during pregnancy or the newborn during delivery and possibly during a short period after birth. The virus has been isolated from fetuses, from cord blood at birth, and from breastmilk. As many as 50% of children born to infected mothers are sero-positive. Most of these children die within one year.

Since there is a possibility that transmission after birth can occur through lactation, concern over the promotion of breastfeeding has grown. However, the risk of effective transmission through ingestion of breastmilk is not known and most experts believe the many benefits of breastfeeding outweigh the risks. Both WHO and UNICEF continue to promote breastfeeding.

As knowledge about the causes of AIDS become more widespread, there could be implications for child immunization campaigns. The reuse of needles is widespread in Africa but to date, in the areas where AMREF works, there has been little or no resistence to injections because of a fear of AIDS. While the use of disposable needles is ideal, the cost factor makes such a strategy not always practical. It is more feasible to encourage the proper sterilization of reusable needles although in hard to reach rural areas where much of the population lives, sterilization is not always easy because of scarce resources (water, fuel). At this point in time, however, the risk of death remains much greater for those children not immunized than for those who are.

AIDS PROGRAMS - CONTENT, COOPERATION, AND INTEGRATION: For those of us actively working in Africa, there is a strong sense of urgency to quickly mobilize resources and begin a series of interventions. However, based on AMREF's experiences with AIDS in East Africa over the past two years, it has become obvious that a number of factors need to be in place before any organzation can effectively intervene. These would include: (1) previous experience in, and knowledge of the country or countries where a project or projects will be carried out; (2) a working relationship with the Ministry of Health and other local indigenous agencies; (3) evidence that planned interventions are consistent with and acceptable to National Committees on AIDS; (4) an ability to integrate AIDS projects into ongoing health programs that are already being carried out in-country (this is to ensure that AIDS efforts become integrated as part of comprehensive health programs and the existing infrastructure); (5) a plan for facilitating replicability in other parts of the country and region.

Program components should include interventions that impact on prevention, service, and a better understanding of the epidemiology of AIDS in the developing nations. Programs related to prevention should focus on health education for groups at risk and the general public, and involve training of all cadres of health and laboratory workers. In addition, applied research on the behavioral aspects of HIV transmission should be encouraged.

Service programs might assist in the development of laboratories for testing as well as designing approaches to managing the tremendous demands for care that are at once compassionate and provide for the survival and perhaps even strengthening of the existing health structure. Epidemiological surveys should be aimed at collecting data in rural locations where PVOs traditionally have had a presence. Maximum value might be achieved if such data collection could be coordinated by specific leadership from the technically sophisticated epidemiology groups linked to the World Health Organization or present at universities.

To begin having an impact on curbing HIV transmission, the need to immediately integrate AIDS interventions into broader based health programs cannot be emphasized enough. In Africa, there is a need to target both high risk groups (prostitutes and their clients) as well as the population at large. It will be necessary to use all existing human resources and the infrastructure in place. To promote safer sex, all cadres of health workers must be utilized as motivators. This can be accomplished by incorporating AIDS education into ongoing training programs offered by Ministries of Health and private organizations.

The linkages between AIDS, population, and family planning are obvious. The growing fear of acquiring the virus should result in the increased use of condoms and other barrier methods. The dual effect might be an increase in the number of family planning acceptors and a less likelihood of HIV transmission through sexual contact.

PVOS - A RESOURCE TO BE UTILIZED: A limited number of private voluntary organizations have the potential to be valuable resources in the struggle against AIDS. In reference to the criteria previously stated for effective AIDS interventions, some PVOs do have (a) proven track records in the countries where assistance is needed (b) previous experience in the health sector (c) community based programs (d) an integrated infrastructure to support such programs (e) indigenous staff (f) linkages to local organisations (g) the ability to work at a national level.

There are PVOs which have 25 or more years of experience working in countries seriously impacted by the AIDS crises. Some of them have been implementing health programs involving both direct delivery of services as well as health education and training. In Africa, the voluntary agencies have tended to focus their programs on the rural areas, where over 80% of the continent's population lives. Most importantly, the PVOs have traditionally been community based, with strong ties at the grass roots level. Given the lack of data from rural areas and the need for community based sero-prevalence studies, PVOs might play an important part in determining the epidemiological scope of the AIDS problem.

Given the need to deal with AIDS in Africa on African terms, it is important to note that many PVOs rely on African staff members in the implementation of their projects. They also have strong links to indigenous non-governmental organizations. Given the key role being played by the National AIDS Committees, and the political implications of the problem, it is those PVOs experienced in working with central Ministries of Health and Ministries of Education that will be in the best position to respond to requests for assistance.

PVOs are ready to add AIDS work to their current health projects and community development activities. PVO demonstration projects should serve as examples to national governments and funding agencies by showing how programs to curb transmission can be organized and implemented in a timely fashion. Through funding of PVO projects, the data and resultant models will be culturally and geopolitically revelvant.

The factor which has limited AMREF's AIDS interventions over the past two years has been a lack of funding. We have made major efforts to attract support from the private sector in the United States, but to date, there has been little response to the international aspects of the epidemic. USAID's initial responses were to the funding of WHO's Global Program on AIDS and the awarding of the AIDSTECH and AIDSCOM contracts. There was little opportunity for PVO funding.

AMREF has been most encouraged in the last few weeks by the announcement of a new USAID Africa Bureau program - HIV/AIDS Prevention in Africa (HAPA). Our understanding is that $20.5 million will be allocated over three years to ensure that the issues of AIDS prevention and control are addressed. The funds will be for intervention related activities and applied research. We have been informed that PVOs are eligible to submit proposals for funding through HAPA and that USAID missions in Africa will play important roles in determining potential implementers. AMREF applauds the Africa Bureau's efforts and along with a number of PVOs, looks forward to cooperating with USAID in the fight to curb the spread of a deadly disease.

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